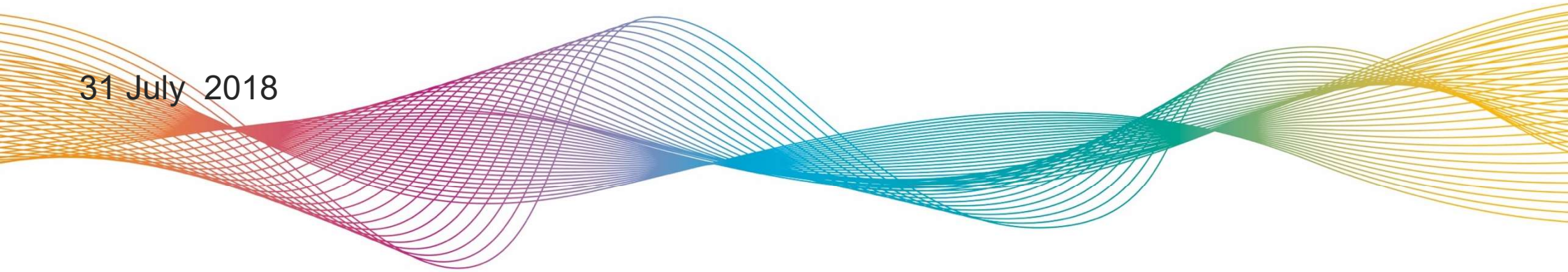
Midlands and Lancashire
Commissioning Support Unit

Reconfiguration of Acute and Maternity Services at University Hospitals of Leicester NHS Trust

Equality and Inclusion Team

Midlands and Lancashire Commissioning Support Unit



31 July 2018

Contents page:

Section	Headings	Page number
1.0	Executive Summary	6
1.1	Assumptions made	8
2.0	Introduction and Background	8
2.1	Legislation requirement	8
2.2	Methodology for the Equality Impact Assessment	14
2.3	Map of Leicester, Leicestershire and Rutland (LLR) area	16
2.4	Current services	16
2.5	Rationale for change	18
2.6	Proposed changes	24
2.7	Interdependencies with other changes	26
3.0	Process of option appraisal work	26
4.0	Demographic and health needs information -	30
4.1	Age and population	31

4.2	Disability	34
4.3	Gender Reassignment	35
4.4	Marriage and Civil Partnership	35
4.5	Race	35
4.6	Religion and belief	37
4.7	Sex	39
4.8	Sexual Orientation	40
4.9	Pregnancy and Maternity	41
4.10	Deprivation	43
4.11	Carers	44
4.12	Asylum Seekers and Refugees	46
4.13	Homelessness	47
4.14	Veterans and Military families	49
5.0	Health inequalities	49
5.1	Other health related data	52
6.0	University of Hospitals of Leicester NHS Trust Performance data	57
7.0	Patients using the hospitals	58
8.0	Travel / transport analysis	60

9.0	Workforce issues	65
10.0	Clinical Assurance	66
11.0	Patient experiences of health services	67
11.1	CQC	67
11.2	Healthwatch	67
11.3	Family and Friends Test	70
12.0	Engagement work so far	71
13.0	Future engagement planned	77
14.0	Impact section	78
14.1	Acute services impact tables for each group	78
14.2	Maternity services impact tables for each group	87
15.0	Next steps / recommendations	96
16.0	Conclusion	98
17.0	Abbreviations	99
18.0	Resources / documents used to support this assessment	100
19.0	Appendices	101
	Appendix A: information on protected characteristics	102
	Appendix B: Maps showing proposed site use	104

	Appendix C: Tables showing proposed location of day case services	106
	Appendix D: Table showing travel analysis information	114
	Appendix E: Table showing postcodes materially impacted by the increased travel times	119

1.0 Executive Summary

This equality impact assessment was carried out during the month of July 2018 to assess the potential equality impacts for the reconfiguration of Acute and Maternity Services at University Hospitals of Leicester NHS Trust. Midlands and Lancashire Commissioning Support Unit have been commissioned to carry out this assessment on behalf of the Leicester, Leicestershire and Rutland (LLR) Sustainable Transformation Partnership (STP) as part of the Better Care Together programme.

The assessment has drawn upon a wide range of existing information, intelligence and previous engagement work. This examines if particular protected characteristic groups or other vulnerable groups are likely to experience any impact from the proposals – either negatively or positively. Assessment work pays particular attention to equality legislation and in particular in showing how the proposed work is considering the needs and views representative of different protected groups under the Equality Act 2010 and Public Sector Equality Duty 2011.

The main findings of this assessment is that current information and engagement work so far does not highlight any **significant** adverse impact or disadvantages for people within protected groups. At a glance tables below show a summary of the impacts identified so far.

Many aspects of the proposals should have positive impacts due to the changes resulting in improved quality of care, addressing staffing problems and addressing waiting times.

Within this assessment there is clear acknowledgement that the changes of location of acute and maternity led birthing units may result in increased travel time and travel cost for some patients across the LLR area. The most significant impact in terms of travel will be for women in or near to Melton Mowbray who would access St Marys. Further work planned for the public consultation will enable this to be explored further.

The assessment highlights a range of recommendations that can be incorporated within the planned public consultation work. The assessment recognises that although **no significant** impacts have been currently identified, the formal public consultation work will provide further robust information to fully assess any impacts relating to protected and other vulnerable groups.

At a glance summary of impacts for acute services proposal - **from section 14.1**

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Age	x		
Disability	x	X travel for some postcodes	
Gender Reassignment			x
Marriage and Civil Partnership			x

Race			x
Religion and Belief			x
Sex			x
Sexual Orientation			x
Pregnancy and Maternity	x		
Staff	x		
Other vulnerable groups such as carers, deprivation.		X travel costs for some postcodes	

At a glance summary of impacts for maternity services proposal - **from section 4.2**

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Age (child bearing age)	x Consultant led births	x Melton Mowbray mums	
Disability			x
Gender Reassignment			x
Marriage and Civil Partnership			x
Race			x
Religion and Belief			x
Sex	x Consultant led births	x Melton Mowbray mums	
Sexual Orientation			x
Pregnancy and Maternity	x		

Staff	x		
Other vulnerable groups such as carers, deprivation	x Overall	x Melton Mowbray	

1.1 Assumptions made within this assessment:

In undertaking this assessment, it is assumed that:

- Formal consultation work has not yet taken place due to an NHS England requirement that a Pre Consultation Business Case must be developed before views within a formal public consultation are sought from the public.
- Previous engagement (insight) work has been carried out and provided an opportunity to gain the perspectives of protected characteristic groups
- The drivers for change emphasise the intention to enhance services and improve the efficient use of resources by reducing unnecessary duplication
- Better Care Together will conduct ongoing assessments as part of the commitment to meeting the Public Sector Equality Duty under section 149 Equality Act 2010 in order to ensure proposals and implementation meets the needs of communities
- Data and information available within the Pre Consultation Business Case will be deemed as accurate and correct

2.0 Introduction and background

2.1 Legislation requirements regarding decision making within the Public Sector

There is a range of legislation that relates to decision making by public bodies and should be complied with in order to reduce risk of legal challenge and make decisions that meet the health and social care needs of communities. These are summarised below:

2.1.1 Equality Act 2010

The Equality Act 2010 protects people against discrimination, harassment and victimisation in relation to housing, education, clubs, the provision of services and work. It unifies and extends previous equality legislation.

The groups the Act specifically covers are called ‘protected characteristics’ these are;

- age
- disability
- gender reassignment
- marriage and civil partnership (with some restrictions)
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

Appendix A provides a summary of the protected characteristics.

Public Sector Equality Duty Section 149 of the Equality Act 2010

The Public Sector Equality Duty in Section 149 of the Equality Act requires public bodies, to pay due regard to the need to:

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity
- Foster good relations

The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantage associated with a protected characteristic
- Taking steps to meet the needs of individuals who share a protected characteristic (where these are different from others)

- Encouraging persons who share a protected characteristic to participate in public life or in any other activity where participation by that group of people is disproportionately low

2.1.2 Brown and Gunning Principles:

To help support organisations to meet these duties a set of principles have been detailed in case law. These are referred to as the Brown and Gunning Principles.

Brown Principles:

- The organisation must be aware of their duty
- Due regard is fulfilled before and at the time any change is considered as well as at the time a decision is taken. Due regard involves a conscious approach and state of mind
- The duty cannot be satisfied by justifying a decision after it has been taken
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision
- The duty is a non-delegable one
- The duty is a continuing one

Gunning Principles:

- Based on Fairness and Proportionality
- Consult at formative stage of the proposal
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response
- Adequate time must be given for consideration and response
- The product of consultation must be conscientiously taken into account

No strategy guarantees 100% compliance or can reduce **all** risks of legal challenge but by following the Gunning Principles for engagement and the Brown Principles for taking 'Due Regard' the risk of judicial review is significantly reduced.

2.1.3 Human Rights Act 1998

The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to.

In practice, the Act has three main effects:

1. It incorporates the rights set out in the European Convention on Human Rights (ECHR) into domestic British law. This means that if your human rights have been breached, you can take your case to a British court rather than having to seek justice from the European Court of Human Rights in Strasbourg, France.

2. It requires all public bodies (including CCG's) and other bodies carrying out public functions to respect and protect your human rights.

3. In practice it means that Parliament will nearly always seek to ensure that new laws are compatible with the rights set out in the European Convention on Human Rights (although ultimately Parliament is sovereign and can pass laws which are incompatible). The courts will also where possible interpret laws in a way which is compatible with Convention Rights.

The Human Rights Act came into force in the UK in October 2000.It comprises of a series of articles which deals with a different right commonly known as 'the Convention Rights'. These include:

- Article 2 Right to life
- Article 3 Freedom from torture and inhuman or degrading treatment
- Article 4 Freedom from slavery and forced labour
- Article 5 Right to liberty and security
- Article 6 Right to a fair trial
- Article 7 No punishment without law
- Article 8 Respect for your private and family life, home and correspondence
- Article 9 Freedom of thought, belief and religion
- Article 10 Freedom of expression
- Article 11 Freedom of assembly and association
- Article 12 Right to marry and start a family
- Article 14 Protection from discrimination in respect of these rights and freedoms
- Protocol 1, Article 1 Right to peaceful enjoyment of your property
- Protocol 1, Article 2 Right to education
- Protocol 1, Article 3 Right to participate in free elections
- Protocol 13, Article 1 Abolition of the death penalty

These rights are taken from the European Court of Human Rights. The withdrawal of the UK from the European Union planned by March 2019 may introduce future changes to the Human Rights Act 1998; however these articles remain in place until any change in law happens.

The articles most relevant to decision making within the NHS are articles 2, 3, 4 (relation to procurement), 8, 9, 10, and 14.

2.1.4 NHS Act 2006:

The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), introduced a legal duty to reduce health inequalities, and placed specific duties on CCGs.

CCGs must have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);

- Exercise their functions with a view to securing health services that are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved (s.14Z1);
- Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities (s. 14Z11);
- Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities (s. 14Z15).

The Act does not define a list of groups impacted by the duties. Any group experiencing health inequalities is covered. The duties take a whole population approach.

Under Section 242(1B) of the NHS Act (2006), we are required to ensure that the public and our patients are informed, involved and consulted in the following areas:

· In planning the provision of services

· In the development and consideration of proposals for change in the way services are provided

· In any decisions to be made affecting the operation of services

CCG's are under a duty by virtue of section 14Z2 of the NHS Act to "secure that individuals to whom [health] services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) –

(a) In the planning of the commissioning arrangements by the group,

(b) In the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) In decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact"

The NHS Constitution states that the NHS has a duty to "…pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population".

The chance of enjoying good health and a longer life is determined by the social and economic conditions in which people are born, grow, work, live, and age. They affect the way people look after their health and use services throughout their life. Health inequalities are unfair and socially unjust.

The NHS Constitution includes pledges linked to patient and public engagement, specifically:

· Information provision to support choice

· Ensuring involvement in service planning and redesign

· Responsibilities to patients including the provision of feedback

2.1.5 Health and Social Care act 2012

The Health and Social Care Act (2012 section 14T) – requires health organisations to clearly demonstrate how they are;

- Reducing inequalities between patients with respect to their ability to access health services and how they are
- Reducing inequalities between patients with respect to outcomes achieved for them by provision of Health services

2.2 Methodology for Equality Impact Assessment (EIA)

This is a pre consultation Equality Impact Assessment (EIA). The author of this report is the Equality and Inclusion team at Midlands and Lancashire Commissioning support unit in collaboration with LLR Better Care Together.

The main purpose of the EIA is to identify and assess any known or potential impacts from proposals and changes to services. These impacts may be either negative or positive. Early identification of equality impacts can help decision makers address emerging equality issues to reduce risks of breaching equality legislation.

This assessment will draw upon previous work with clinicians, stakeholders and public engagement work to evidence how the Better Care Together are evidencing how they are showing 'due regard' to meeting their Public Sector Equality Duty (PSED) within the proposed plans for the reconfiguration of Acute and Maternity services at University Hospitals of Leicester NHS Trust.

This assessment will collate a range of information that will help identify potential equality issues and risk as the proposals are prepared for the next formal phase of public consultation. This work is ongoing and will also help identify gaps where further information will help decision makers discharge their equality duties.

This assessment will include how LLR Better Care Together are discharging their Public Sector Equality duty to:

1. Ensure that proposals and any decision making do not discriminate, harass or victimise those with protected characteristics
2. That proposals and any decision making advance equality of opportunity between different groups
3. That proposals and any decision making fosters good relations between different groups with protected characteristics and those with without a protected characteristic

In addition, the assessment gathers evidence of how Better Care Together are meeting the legal requirements under the Health and Social Care Act (2012) 14T Duties as to reducing inequalities, by having due regard to the need to:

a) reduce inequalities between patients with respect to their ability to access health services and
b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

Equality Impact Assessments present information on **how** 'due regard' has been demonstrated by organisations in the planning and decision making process, rather than 'doing due regard'.

The information and intelligence that will be used to inform this assessment:

- Demographic profiles for communities affected by the proposals
- Projected demographic information for communities
- Health inequality information from public health and JSNA data
- Hospital data
- Previous engagement work with stakeholders, public and staff
- Any disaggregated work linked to previous engagement relating to protected characteristics and vulnerable groups
- Contextual information at national and local level including the pre engagement business case
- Review work and inspection reports – national, local and statutory bodies
- Infrastructure issues such as travel and transport factors

In this assessment, the demographic and health inequality data will be gathered using Joint Strategic Needs Assessments (JSNA). JSNA analyse the health needs of populations to inform and guide commissioning of health, wellbeing and social care services within local authority areas.

The last JSNA report available was compiled in 2015. Data is presented on an on-line website. All of the dashboards have been developed to include data on Leicestershire County Council and the 7 district councils, Rutland County Council, plus Leicester City and the two Leicestershire and Rutland CCGs of West Leicestershire, and East Leicestershire and Rutland.

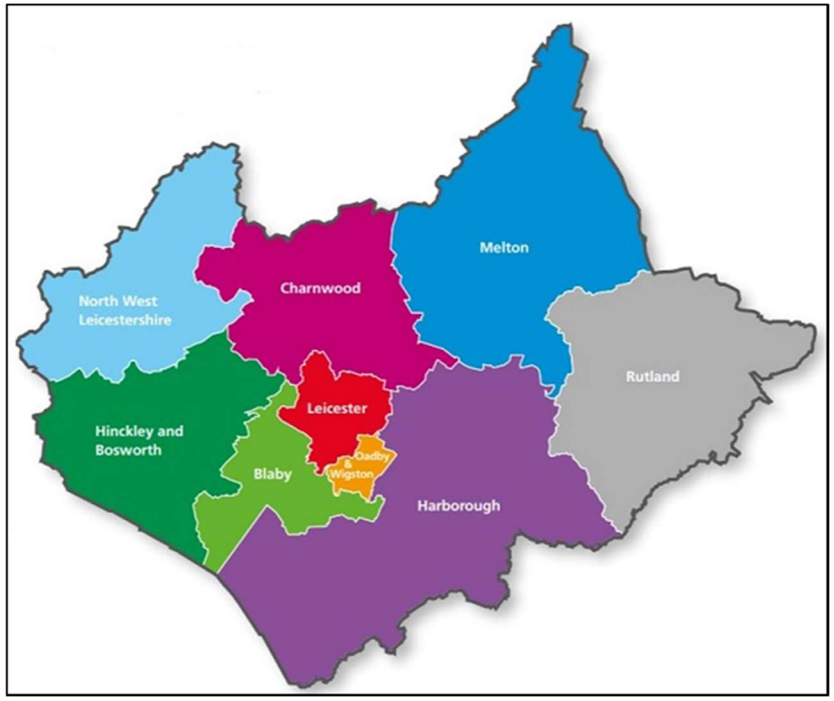
Source: http://www.lsr-online.org/leicestershire-2015-jsna.html

In an end-to-end EIA process, senior decision makers carefully consider any identified potential equality impacts and equality risks before making final decisions about healthcare services for local populations. The process enables decision makers to consider feedback from an early stage of the decision-making process as this may lead to subsequent mitigation or re-shaping of services where possible to address equality issues.

The process of EIA work provides assurance that decision makers are meeting the legal requirements of equality legislation and is an integral part of any proposal.

NHS organisations are responsible for making decisions within a challenging backdrop of increasingly limited resources which must be allocated in line with shared priorities within LLR health and social care economy, and in striving to maximise resources to achieve the best possible outcomes for all patients.

2.3 Map of the LLR area:



2.4 Current services:

This section outlines current acute and maternity services and the rationale for change.

Current acute services:

Within the LLR area there are currently three large hospitals providing acute services.

Acute services are provided by University Hospitals of Leicester NHS Trust with operate from main three hospital sites of:

- Leicester Royal Infirmary (LRI)
- Glenfield Hospital (GH)

- Leicester General Hospital (LGH)

The LRI is located within the centre of Leicester, with LGH being located to the east on the outskirts in Evington and GH located on the outskirts to the west side of Leicester

The LRI has undergone recent redevelopment work for an Emergency Department and assessment unit. The GH is the location for the areas Cardiovascular centre. Both LRI and GH have a level 3 ICU in development which has relocated from LGH.

This was previously located at LGH and has already relocated. A mix of acute services for adult, women's and children's care currently run from both LRI and GH. Tables showing the proposed relocation of services can be found in Appendix C.

Current Midwifery Services:

Current services include:
A standalone Midwife Led Birthing Unit currently operates from St Marys district hospital in Melton Mowbray offering 24 hour service, 2 birthing rooms and 8 post natal beds. (post natal beds are an unusual feature of midwife led birthing units as the expectation is that mothers and their babies are discharged shortly after the birth)

- Midwife Led unit currently operates from LRI
- Community Midwifery services work across the area
- Postnatal services work across the area
- Home births service is offered across the area
- Neonatal care level 1 is provided at LGH and LRI. Level 2 and 3 (for higher level care) is provided at LRI only

Table showing babies born.

UHL TOTAL REGISTERABLE BABIES Data	2013/14 Actual	2014/15 Actual	2015/16 Projected	Total
LRI	5942	6097	6005	18044
LGH	4235	4451	4636	13322
SMBC	224	188	172	584
Total	10401	10736	10812	31949

Sustainable number for Midwife Led Units is a target of 500 births.

Table showing types of births UHL data:

Type of Birth	Percentage
Home birth	1.50%
Standalone midwife led	1.50%
Stand aside midwife led	22%
Consultant care	75%
Total	100%

The type of births relate to The Department of Health National Review on Maternity Services 2016 (*Better Births*). This relates to patient choice including Midwife Led Birthing Units and Home Births. Further information is provided below.

2.5 Rationale for change:

This work has developed within the context of national government policy and local strategies.

In summary, the operation of running 3 large hospitals are problematic with:

- specialist staff being spread too thin across the 3 sites
- duplication and triplication of services across the 3 sites
- expensive running and maintaining 3 sites

The proposal has been developed by the Better Care Together programme as part of the Sustainability and Transformation Partnership to transform health and care systems in Leicester, Leicestershire and Rutland (LLR). As part of the Better Care Together programme, a number of key changes have already been implemented or in the process of being implemented. These include the redevelopment of new Emergency Department at LRI, relocation of Vascular Services and Intensive Care Unit.

There are also wider system problems which have been recognised by the Better Care Together programme. These include:

- Employee experience – staffing pressures
- Increasing demand and use of the health care system – especially in urgent and emergency care services
- Demands on the system – waiting times for treatment
- Improving privacy and dignity
- Patients at high risk are not always based at the site with emergency services
- Variations in the clinical outcomes depending on where people live and where they receive their treatment
- Joined up care outside of hospital settings within neighbourhoods
- Management of patients with long term chronic conditions

- Financial position – acute care accounts for 42% of health care funding in 2017/18. This is expected to increase by 5.1% leaving an annual deficit of £169 million for acute care by 2021/22 without the reconfiguration. Ongoing cost saving initiatives are not sufficient to close this gap.

In terms of rationale for needing to change services delivered by St Mary's, the number of births at St. Mary's Melton Mowbray is steadily declining year on year. Based on this activity, St Marys is not financially viable. The number of births that take place there is only 1.78% of the total number of births at UHL. Of these births, 27% of cases are transferred to the acute unit because of complications. A birth at St Marys costs £2762 compared to £1668 at LGH and LRI. Review work across the area has found that St Marys is not easily accessible for most people across the LLR area, as such, it primarily serves a local population, 60% of women coming from Melton.

There are also concerns as to the state of the buildings on the St Marys site. A review of the building in 2014 identified a number of site and building issues. They estimated a refurbishment cost in the region of £0.8 to £1m and suggested as an option that the trust should consider site disposal and relocation of services.

Context of the LLR Better Care Together Programme: developed from January 2014 to support commissioning and quality of services across Leicester, Leicestershire and Rutland. The programme continues to develop transformation of services and integrated working through the Sustainability Transformation Partnerships.. The Better Care Together Programme involves:

- Three CCG's – Leicester City CCG, West Leicestershire CCG and East Leicestershire and Rutland CCG
- University Hospitals of Leicester NHS Trust (Acute Hospital Trust)
- Leicestershire Partnership Trust (Mental health provider)
- East Midlands Ambulance Service NHS Trust
- Local Authorities and their Health and Wellbeing Boards – Leicester City Council, Leicestershire County Council and Rutland County Council
- Healthwatch organisations – Leicester City Healthwatch, Leicestershire Healthwatch and Rutland Healthwatch
- Additional groups from voluntary, community and private sector
- Patient and Public Involvement membership

Since 2014 the LLR Better Care Together Programme has developed a detailed understanding of the challenges on local health services.

- Emergency Department performance
- Ambulance waiting times
- Changes in age profiles and related increase of health needs
- Need to improve quality and standard of care

- Financial sustainability and requirement for greater efficiency
- Workforce

Partner organisations delivering the Better Care Together programme are committed to making sure that equality, diversity and inclusion considerations are embedded within decision making processes for the reconfiguration of healthcare services. They are committed to working meeting equality legislation and mandated equality requirements from NHS England. Some examples of the collaborative arrangements in place for promoting and monitoring equality work include:

- Sustainability and Transformation Partnership Five Year Strategic Plan
- Use of Joint Strategic Needs Assessment (JSNA)
- Overview and Scrutiny Committees
- Healthwatch involvement
- Stakeholder involvement

Better Care Together work relating to Maternity Services:

Projected number of births across LLR are expected to increase.

Predicted Births						
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Births at UHL	10,534	10,745	10,960	11,179	11,403	11,631
Births in LLR	12,458	12,707	12,482	12,483	12,158	12,482

The overall increase is also expected alongside an increase in complexity. Complexity is related to a number of factors including:

- High rate of teenage conceptions in Leicester City compared to the national average
- Rutland has a higher percentage of mums giving birth over the age of 40 years compared to the national average
- LLR area having number of Asylum Seekers / Refugees living in the area
- Mums presenting with substance misuse problems
- Mums presenting with long term conditions – mental health / chronic conditions

Supporting table of factors relating to vulnerability:

Indicators Related to Vulnerable Groups from Public Health LMS "Fingertips" Profiles			
Indicator	Leicester	Leicestershire	Rutland
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups	53.1	11.9	8.2
Deprivation Score (IMD 2015)	33.1	12.5	9.6
Under 18 Conceptions (per 1,000 females aged 15-17)	26.2	16.3	5.7
Infant Mortality (per 1,000)	5.1	3.9	4.9

National context - rationale:

- **NHS Five Year Forward View** (5YFV): this was published by NHS England in 2014 and provided national priorities and direction for NHS services with an emphasis on greater integration within health care and social care. The 5YFV provided a vision for how future healthcare services will be delivered. These include:

    - G.Ps working closely with nurse teams and other health and social care professionals to provide patients with integrated care within the community
    - Integrated working between hospital and primary care providers
    - Redesigning urgent and emergency care services to meet increased demand
    - Development and use of technology to improve the management of patient care
    - Delivering efficiency savings through developing new models of care and wider system improvements

- **Carter Review:** examined productivity and efficiency across non specialist acute hospitals in England. The review highlighted that by addressing variation could save the NHS £5 billion. The review highlighted the need for NHS trusts to improve on:

    - Unused floor space
    - Estates and their cost
    - Energy savings

- **Naylor Review:** this national review was carried out in March 2017 and made 17 recommendations to the Secretary of State for Health on use of estates and NHS properties to make best use of capital available.

- **The Department of Health National Review on Maternity Services 2016 (*Better Births*):** This national review has:
    - Provided the opportunity to refresh the current model within LLR
    - Provide direction of travel for the next five years and beyond for maternity and neonatal services across LLR

What is happening in LLR to meet national initiatives under Better Births:

1. Implementation of an LLR local maternity dashboard, along with the development of partnership pathways and strategies to support areas such as transition to parenthood, infant feeding and reducing infant mortality. It also has an existing Maternity Services Liaison Committee which will supports the development of local Maternity Voices Partnerships.
2. Over the last five years, significant work has been undertaken locally in relation to improving and maintaining quality to ensure a safe and sustainable maternity service. This has resulted in significant investment in midwifery, neonatal and other obstetric services.

Challenges arising from Better Births:

Maternity services face challenges in relation to demographic issues, especially in Leicester City and more generally in relation to capacity of the services to cope with increasing demand and complexity. Maternity facilities in UHL were designed to cater for approximately 8,500 deliveries per year, but deliveries now total approximately 10,534 per year.

In line with Better Births, The Better Care Together Programme have developed and subsequently updated baselines and year on year targets until 2021. These include five specific areas of:

1. Safety
2. Personalised care
3. Patient choice
4. Continuity of the person caring for them during pregnancy, birth and postnatally
5. Midwife Led Birthing Units and Home birth services

1: Safety

This includes clear plans to improve the safety of maternity care with the aim to reduce rates of still birth and neonatal death, maternal death and brain injuries during birth by 50% by 2025.

Current performance in LLR (year 2015) notes that there are 6.79 still births per 1,000.

By reducing our rates by 0.5 each year, we will be on track to meet the national target of reducing our number of stillbirths by 50% in 2025.

This target is being monitored by NHSE including women who live in LLR and women who choose to use cross-border providers.

Risks and work to reduce risks:

- need to have regular multi-agency reviews of performance in this area
- influence over cross-border providers to maintain the required reductions in still births to meet the target in 2025.
- To mitigate these risks LLR are currently opening communication channels with neighbouring Local Maternity Services to obtain the required information regarding outcomes of women who choose to give birth outside of LLR and will formulate an action plan once data has been received.

2: Personalised Care Planning (PCP)

All women who attend a booking appointment receive a hand-held record which contains the agreed plans for her care and provides a basis for the booking conversation with their midwife. This is also used to record both medical data and personal information such as hopes and expectations of pregnancy, birth and postnatal care.

Current performance in LLR is 50% of pregnant women receive a hand held record

By increasing the number of women who receive PCP by 17% per year, we will reach 100% by 2021.

LLR will also promote consistency in how midwives are helping women to fill out their PCP. We will ensure women are supported to complete the plan if they have any additional language/literacy needs

Risks and work to reduce risks:

- There is a risk that not all women will engage with midwives to create a fully functional PCP
- To mitigate this, LLR will work closely with our Maternity Voices Partnership (MVP) to ensure our pathways are as inclusive as possible and can be used to target groups of people who may be more vulnerable or are part of a community that is less likely to engage

3: Improve choices available so that all women can make choices about their maternity care as envisaged in Better Births.

My NHS suggested only 64% of women across LLR felt that they had appropriate choice in their care. Because LLR offer all recommended birthing options, investigations are underway to ascertain whether this is in relation to choices available in antenatal and postnatal care.

By increasing the number of evidenced choice offers by 12% each year we will reach 100% by 2021.

Risks and work to reduce risks:

- Choice may not be offered consistently across antenatal, intrapartum and postnatal elements of the pathway.

- To mitigate this, women's perception of their choice is being included on all feedback and monitoring systems and it will be a key piece of work when the Maternity Voices Partnership is up and running.
- There is also a risk that choice will be reduced, with proposals to St Mary's Hospital.

4: Receive continuity of the person caring for them during pregnancy, birth and postnatally

Local data indicates that 2% of LLR women receive care from the same midwife throughout their pregnancy and birth including postnatal care. Whole-pathway continuity is currently only provided by specific teams within LLR maternity services such as the Homebirth Team and St. Mary's Midwife Led Birthing centre.

LLR will increase the percentage of women receiving whole-pathway Continuity of Carer to 20% by March 2019

Risks work to reduce risks:

- There is a risk that we will be unable to meet the target due workforce issues of recruitment and different ways of working.
- There are challenges with working time directive.
- To mitigate this, the Better Care Together Programme are reviewing workforce models

5: Enable more women to give birth in midwifery settings (at home and in midwifery led birthing units)

Current data for 2016/17 indicate that 23% of births met this target. By increasing the number of women who give birth in midwife-led settings by 2.3% per year, we will reach 30% by 2021.

Risks and work to reduce risks: There is a risk that women will choose not to give birth in midwife-led settings. This will be mitigated by promoting these settings and working with other agencies such as Public Health to understand the concerns and anxieties of women and increase the uptake of midwife-led care amongst the culturally diverse population in LLR.

The context of national initiatives under Better Births are important driver for the reconfiguration of Maternity Services as the Better Care Together Programme in order to meet the targets and improve patient care.

2.6 Proposed changes – acute services:

The proposal within the Pre Consultation Business Case is to:

1. Move acute services from 3 sites onto 2. This will mean that the majority of services will move for LGH to GH and LRI.
2. Retain some non acute health services at LGH

Proposals for the LRI and GH site include:

- Acute services moving from LGH will be accommodated within either LRI or GH
- LRI is the primary site for Emergency Care
- New build facilities at LRI to accommodate a new Maternity Hospital, Gynaecology Services, Adult Surgical Services and a Super ICU
- New build development at GH to accommodate treatment centre and new wards including new treatment centre for outpatients, 23 hours care, new theatres and imaging facilities
- Expansion to Mortuary, pathology and pharmacy on the GH site
- Paediatric services will come together in a new Children's Hospital located on the LRI site.
- Brain injury and Neurological Rehabilitation Unit will move from LGH to LRI due to this site being primary site for Emergency Care
- A new welcome centre will be built on both GH and LRI sites
- Additional parking will be provided on the LRI site to accommodate increase demand

Proposals for LGH site include:

- Majority of acute services will move to LRI or GH
- Some services will be retained on the site. These include:
    - The Leicester Diabetes Centre of Excellence. This is currently accommodated in a self-contained building that will be maintained independently to the rest of the accommodation
    - Haemodialysis Unit is under consultation with possible move to GH
    - Dedicated GP Access Imaging Hub – to provide an independent facility to alleviate demand on the other acute sites
    - Stroke Rehabilitation – located in the Evington Centre on the site
    - The Brandon Unit use will be for back office functions such as administration
    - A standalone Midwife Led Birthing Unit – within the Coleman Centre
- Long term plan to decommissioning the LGH site for housing development use

Maps showing the proposed new sites are shown in Appendix B.
Information tables showing changes in location of acute services are shown in Appendix C.

Proposed changes – maternity services:

The reconfiguration of maternity services centres on:

1. Development of a new maternity hospital on the site of LRI which will accommodate both Midwife Led Birthing Unit and Consultant led birth

2. Midwife Led Birthing Unit at LGH. Midwife Led Birthing Unit proposed for LGH for a one year pilot with a view to sustaining 500 births a year
3. Closing the Midwife Led Birthing Unit at St Marys Hospital at Melton Mowbray

Community Midwife services, Post natal services and Home Birth service will remain unchanged.

This assessment acknowledges that whilst aspects of the birth experience within a Midwife Led Birthing Unit and home birth are similar there may be reasons why some women may prefer the choice of a Midwife Led Birthing Unit due to their home conditions being unsuitable for a home birth.

2.7 Interdependencies with other changes:

- A number of services have already moved from LRI to GH (Vascular, Elective Orthopaedics, Hepatobiliary, Renal Medicine and Urology)
- Delivery of trauma care
- Primary care services and community care
- Principle of home first
- Link with improvement of the management of patients with co-morbidities with the aims to prevent hospital stays
- Greater use of IT systems
- Sharing of IT systems such as health records, electronic discharge across health and social teams
- LLR frailty and morbidity programme
- Leicester Health and Social Care Integration Programme

3.0 Process of options appraisal work:

This section demonstrates how different options were evaluated and how proposed preferred options were decided.

3.1 Acute services options appraisal:

The appraisal option process for reconfiguration of acute services started in 2013. 8 options were identified for evaluation. This work was carried out in workshops involving teams from Adult and Children's services. This was endorsed by the Executive Strategy and UHL Trust Board. A wide range of stakeholders, clinicians, staff and patient representatives were involved in the option appraisal work.

The process involved:

- Agreement of approach
- Evaluation work of each option

- Qualitative scores for short listing options
- SWOT analysis

Review work including a SWOT analysis highlighted the following for each hospital site:

Leicester Royal Infirmary:

- Limited parking (weakness)
- Poor signage and poor entrance area (weakness)
- Location easily accessible by public transport
- Estate facilities such as electrics / water ring running with capacity (strength)
- Estates condition requires attention (weakness)
- Gas supply running beyond maximum (threat)
- Potential freed up space if some services moved relocated
- Traffic congestion on site

Glenfield Hospital:

- Generous parking allocation (strength)
- Estates condition is good (strength)
- Site infrastructure needs some improving to gas supply, catering facilities and lease hold arrangements
- Transport routes may require improvement to cope with increase traffic demands onto the site
- Local residents may have objections to developing the site

Leicester General Hospital:

- Hospital location is easily accessible to the public with good public transport links (strength)
- There is poor signage with no obvious entrance. There are long patient journeys between different departments (weakness)
- Limited parking availability – congestion on Havelock street (weakness)
- Congestion on site makes blue lights emergency access compromised (weakness)
- Community and patients are accustomed to travelling to LRI for higher needs (weakness)
- Site infrastructure issues – due to façade, gas supply and lease hold arrangements (weakness)

The appraisal work for acute services led to the preferred option of delivering acute services across LRI and GH, with an Outpatients and Day Case hub at GH. This was deemed as the best option for achieving the revenue savings. The long term plan for the LGH is decommissioning the site.

3.2 Maternity services option appraisal:

The appraisal option process for reconfiguration of maternity services started in 2015 following initial work in 2010. This process identifies where acute services were to be located. A wide range of stakeholders, clinicians, staff and patient representatives were involved in the option appraisal work.

Previous review of Women's Services determined location of obstetrics, co-located midwifery services adjacent to obstetrics unit and neo-natal services.

It examined options on location of the Midwife Led Birthing Unit including option of continuing the Midwife Led Birthing Unit at St Mary's. Feasibility options were developed through work with:

- Clinicians
- Commissioners
- Health workers
- Public representatives
- Insight meetings – workshops

The above work produced 8 options where underwent a shortlisting process. This process did not include community midwife services, antenatal care and home birth services.

The main option considered within the appraisal option process was to review the option to have a standalone Midwife Led Birthing Unit or have none. The viability and sustainability of a standalone Midwife Led Birthing Unit is dependent on it delivering 500 or more births.
Table showing impact on the numbers of births with consideration of different locations with LLR:

Potential Midwife Led Birthing Unit Site	**Estimated inpatient stays based on post code proximity**	**Rank**
LRI	1295	2

LGH	1441	1
Melton Mowbray St Mary's	269	7
Rutland Memorial Hospital	90	9
St Luke's hospital Market Harborough	173	8
Fielding Palmer Hospital Lutterworth	439	5
Loughborough Hospital	612	3
Hinckley and Bosworth	561	4
Coalville	379	6

The appraisal process led to the proposal that:

- Closure of Midwife Led Birthing Unit at St Marys Hospital was unsustainable due to low numbers of births
- Standalone Midwife Led Birthing Unit to be located in Leicester – at the LGH as a pilot for 1 year to evaluate number of births for future viability. Part of the reason for this was the projected increase of births in coming years are expected within the Leicester City area.
- Women who wish to have a consultant led birth can still attend the LRI

During the process, reasons for low numbers of births at St Marys Hospital were given relating to its geographic location, and the suggestion that women may prefer to have their baby at a Midwife Led Birthing Unit on a site with obstetrics support. UHL note within their business case work that women would be willing to travel longer distances (if less than 15 minutes) to attend LRI if there was potential access to a state of the art obstetrics unit. This issue questioned the sustainability of a standalone Midwife Led Birthing Unit at LGH. For this reason, the proposals include that any standalone Midwife Led Birthing Unit at LGH would be a one year pilot to monitor the number of births per year and review safe staffing levels.

3.3 Evaluation of the Appraisal process:

Both Acute and Midwife option appraisal work examined a range of different objectives. Many of these linked with opportunities for equality considerations to be provided. These included:

- Quality of environment
- Improving patient privacy and dignity
- Improving access to services
- Providing a safe and secure environment
- Optimising the patient journey
- Addressing national guidance
- Addressing equality legislation
- Enhancing the quality of life for patients with long term conditions
- Satisfying a range of stakeholders
- Improving staff experience

The process was undertaken by a range of different stakeholders, staff, clinicians and patient representatives.

3.4 UHL Estates Strategy:

The proposals are closely aligned to the UHL Estates Strategy. In summary the strategy the estates needs to be:

- Functionally suitable
- Located to provide the highest level of accessibility for patients, visitors and staff – in compliance with the Equality Act 2010
- Estates designed and maintained to deliver high quality clinical environments
- Estates well utilised, cost effective and environmentally efficient
- Provides an inclusive environment

4.0 Demographic and health needs information

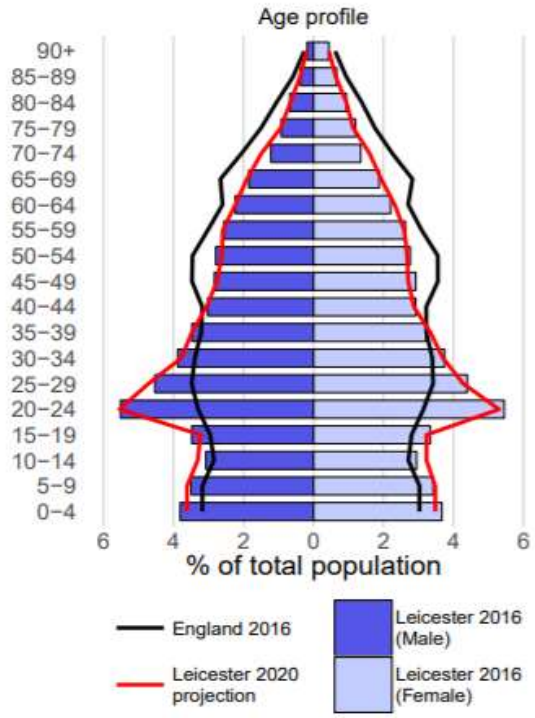
This section of the assessment has collated from JSNA and Public Health data sets. This section provided available data about different groups within the population together with additional information relating to health needs. Data is provided for:

1. Leicester City
2. Leicestershire
3. Rutland

4.1 Age and population:
Data within the LLR draft November 2016 notes that the population of LLR is just over 1 million (1061800)

Data from Public Health England health profiles show age profiles for each of the areas within LLR.

Age profile Leicester: The following age profiles are from public health source.



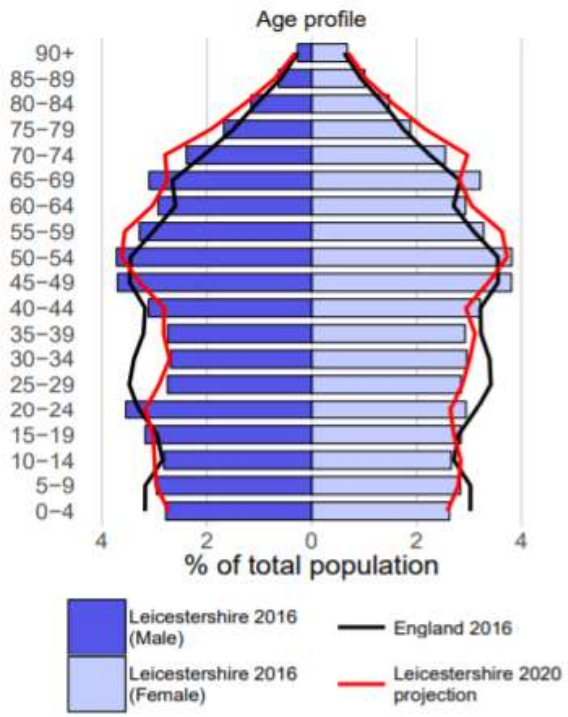
Understanding the sociodemographic profile of an area is important when planning services. Different population groups may have different health and social care needs and are likely to interact with services in different ways.

	Leicester (persons)	England (persons)
Population (2016)*	350	55,268
Projected population (2020)*	362	56,705
% population aged under 18	23.8%	21.3%
% population aged 65+	11.7%	17.9%
% people from an ethnic minority group	48.6%	13.6%

* thousands

Source:
Populations: Office for National Statistics licensed under the Open Government Licence
Ethnic minority groups: Annual Population Survey, October 2015 to September 2016

Age profile Leicestershire:



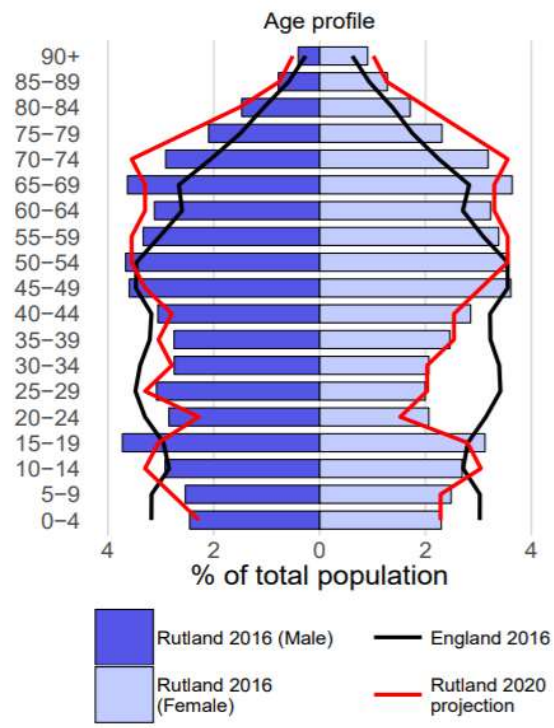
Understanding the sociodemographic profile of an area is important when planning services. Different population groups may have different health and social care needs and are likely to interact with services in different ways.

	Leicestershire (persons)	England (persons)
Population (2016)*	680	55,268
Projected population (2020)*	701	56,705
% population aged under 18	20.1%	21.3%
% population aged 65+	20.0%	17.9%
% people from an ethnic minority group	7.8%	13.6%

* thousands

Source:
Populations: Office for National Statistics licensed under the Open Government Licence
Ethnic minority groups: Annual Population Survey, October 2015 to September 2016

Age profile: Rutland:



Understanding the sociodemographic profile of an area is important when planning services. Different population groups may have different health and social care needs and are likely to interact with services in different ways.

	Rutland (persons)	England (persons)
Population (2016)*	39	55,268
Projected population (2020)*	39	56,705
% population aged under 18	19.9%	21.3%
% population aged 65+	24.2%	17.9%
% people from an ethnic minority group	0.9%	13.6%

* thousands

Source:
Populations: Office for National Statistics licensed under the Open Government Licence
Ethnic minority groups: Annual Population Survey, October 2015 to September 2016

Analysis of Age profile data sets: Population growth for Leicestershire showing significant increase in population for people aged 85 and over. Each of the areas within LLR show differing age profiles. Leicester City has a younger demographic with significantly more people aged 20-29. This may be due to the town being home to Universities and places of study.

JSNA information shows that across LLR, there are fewer older people than nationally, but complex needs – isolation, poverty, frailty, increasing dementia. Increasing numbers of older people, mostly women caring for others. (cross reference with carers section) Prevention, early diagnosis, care or carers, integrated care pathways, collaboration between health and social care are key issues.

4.2 Disability

JSNA data sets shows that:
Dementia: Across LLR there are 2700 people suffer with dementia, will increase to 3,700 people by 2030. Currently 800 new cases a year. 70 younger people with dementia. Early diagnosis, care of carers, integrated care pathway, collaboration between health and social care are issues. Specific Needs Assessment undertaken in 2011/12 to inform detailed commissioning. Cross reference with Healthwatch section on dementia services.

Learning disability: Across LLR there is a significantly higher proportion of over 18 year olds registered with a learning disability than is found either nationally or in the East Midlands. Estimates suggest that just under 5,900 adults with any learning disability live in the city of whom around 1,245 have needs that require social care support, 997 of whom are in receipt of this. People with learning disabilities are under recorded on GP registers.

Physical disabilities: the prevalence of physical disabilities is greater than the number of people who need services, though estimates suggest that just under 4,000 people aged 18-64 are thought to have a serious physical disability in Leicester, 234 of whom are in receipt of social care.

Visual impairment: Across LLR there are an estimated 3,000 people living with sight loss. Of the 2,233 individuals on the vision impairment register, 73% are aged over 60 years. As well social care and health needs there is a considerable primary and secondary prevention agenda including eye health, a reduction in smoking and ensuring that the potential of sight loss is clearly addressed in the on-going education and care of people with diabetes.

Hearing impairment: Population projections for Leicester show that there are an estimated 21,503 people with a moderate or severe hearing loss in Leicester and this is set to rise to 29,830 by 2030. Those with a profound hearing loss were estimated to be 454 people in 2011, set to rise to 660 by 2030. A large proportion of the hard of hearing community is over 65 years.

In May 2018, a review into the deaths of people with learning disability by NHS England highlighted significant concerns surround the care of patients with learning disabilities. This report details problems in the quality of care, delays in treatment and the health of this group was adversely affected by numerous factors surrounding their care. Specific recommendations within the report relate to hospital services such as:

- Creation of health passports
- Improved signage about waiting time in A&E
- Review discharges to ensure they are appropriate
- Follow up non attendances

Source: https://www.hqip.org.uk/resource/the-learning-disabilities-mortality-review-annual-report-2017/#.W1dn2tJKg2x

4.3 Gender Reassignment

Stonewall produced a report on transgender experiences in 2018. A significant number of trans people face poor treatment when accessing healthcare services, despite the legal duty of all health and social care organisations to provide equal treatment and tackle discrimination.
Source: https://www.stonewall.org.uk/sites/default/files/lgbt-in-britain-trans.pdf

Population on this group is not collated within national census data. Estimate figures are thought to be in the region of 0.5%.
Source: Stonewall

4.4 Marriage and Civil Partnership

The protected characteristic relates only to employment and not service provision. Within the context of this assessment the impact can relate to workforce issues.

For this assessment the hospital workforce data profile reports provided data on employees rates for marriage and civil partnership. Across the UHL trust, 53% of staff disclosed they are married and 0.6% disclosed that they are in a civil partnership. The general census data indicates that marriage rate is 42.4% compared to the England rate of 46.6%. Civil partnership is 0.2% comparable to the England rate of 0.2%. UHL data was collated in March 2017. The differences within local trust data and national census data may be due to census being carried out in 2010 and civil partnership becoming more popular within the last 5 years.

Sources: ONS
Workforce profile data: http://www.library.leicestershospitals.nhs.uk/pubscheme/Documents/Equality%20and%20Diversity/2016-17%20Final%20Workforce%20Report.pdf

4.5 Race

Cross reference to the Age section 4.1 which shows tables containing Ethnic Minority data.

Cross reference to section on Asylum Seekers and Refugees.

Table showing ethnic groups across the LLR area:

Area	Ethnic Minority Data	Analysis of data set
Leicester City	48.6%	Leicester City has a higher rate of people from ethnic backgrounds compared to the England population.
Leicestershire	7.8%	
Rutland	0.9%	

England	13.6%	Rural areas within the LLR, have low rates of ethnic minority groups – Rutland and Leicestershire. Source: ONS Annual Population Survey October 2015 to September 2016 contained within Public Health profiles.

JSNA information shows that LLR has a diverse population compared with England as a whole. The age profile of Leicester's BME population is younger than the White population.

JSNA information for the different backgrounds within Leicester City:

	Leicester City		England
Ethnic group	Number	%	%
White: British	183,000	60.1%	82.8%
White: Irish	3,200	1.1%	1.1%
White: Other White	9,100	3.0%	3.6%
Mixed: White and Black Caribbean	3,100	1.0%	0.6%
Mixed: White and Black African	900	0.3%	0.2%
Mixed: White and Asian	2,900	1.0%	0.6%
Mixed: Other Mixed	1,900	0.6%	0.5%
Asian or Asian British: Indian	56,900	18.7%	2.7%
Asian or Asian British: Pakistani	14,000	4.6%	1.9%
Asian or Asian British: Bangladeshi	2,800	0.9%	0.7%
Asian or Asian British: Other Asian	5,800	1.9%	0.7%
Black or Black British: Black Caribbean	4,800	1.6%	1.2%
Black or Black British: Black African	5,800	1.9%	1.5%
Black or Black British: Other Black	1,000	0.3%	0.2%
Chinese or Other Ethnic Group: Chinese	6,500	2.1%	0.8%
Chinese or Other Ethnic Group: Other	3,000	1.0%	0.8%
All Groups	304,700	100.0%	100.0%

Please note that this data set is 2009 estimates however demonstrates the diverse mix of different groups residing in the area.

There is evidence of the links between ill health and ethnicity. This may be due to a range of complex factors such as deprivation, lifestyle factors and genetic factors.

Cross reference with section 5.0 on health inequalities .

Gypsy and Traveller communities:

Within ethnic background, Gypsy and Travellers are a minority group which there is limited information.

A report carried assessing the accommodation needs for travellers in 2013 by DeMontfort University found:

- Estimated population of 468 families living in LLR
- 87 people took part in the research
- 40 from 87 (46%) reporting health problems
- Respondents noted that there was a link between registering with health services and having settled accommodation
- 11 respondents were specifically referred to help they had received from members of the Gypsy/Traveller health team either in getting them registered with health services, or in helping them to attend specialist appointments
- There is a specialist health service for Travellers based out of the New Parks Health Centre which is referred to in very positive terms by Gypsies and Travellers and professionals at Multi Agency Traveller Unit (MATU)

Source: www.blaby.gov.uk/

4.6 Religion and Belief

ONS data on religion and belief for Leicester shows:

The order of the main religious groups *by size* changed between 2001 and 2011.

Those affiliated with the Christian religion remain the largest group; 32 per cent of usual residents. This is a decrease of 13 percentage points since 2001 when 45 per cent of usual residents stated their religion as Christian. It is the only group, other than Jewish, to have experienced a decrease in numbers between 2001 and 2011 despite population growth. This pattern is mirrored at both regional and national level.

The second largest response category in 2011 remains no religion. This increased 6 percentage points from 17 per cent of usual residents in 2001, to 23 per cent in 2011.

Those affiliated with the Muslim religion are now the third largest group (19 per cent); an increase of 8 percentage points since 2001.

	Leicester		East Midlands		England	
	Number	%	Number	%	Number	%
Christian	106,872	32.40	2,666,172	58.80	31,479,876	59.40
Buddhist	1,224	0.40	12,672	0.30	238,626	0.50
Hindu	50,087	15.20	89,723	2.00	806,199	1.50
Jewish	295	0.10	4,254	0.10	261,282	0.50
Muslim	61,440	18.60	140,649	3.10	2,660,116	5.00
Sikh	14,457	4.40	44,335	1.00	420,196	0.80
Other religion	1,839	0.60	17,918	0.40	227,825	0.40
No religion	75,280	22.80	1,248,056	27.50	13,114,232	24.70
Religion not stated	18,345	5.60	309,443	6.80	3,804,104	7.20
All people	**329,839**		**4,533,222**		**4,533,222**	

Source ONS

Leicester has the third highest proportion of people of Hindu faith of any place in England and Wales

Source; Diversity and Migration. Leicester City Council, December 2012

It is generally accepted that religion and belief can play a significant part in the decision making when people or family members become unwell. Access to chaplaincy services are an important part of the pastoral and spiritual care offered and provided within current health services including end of life care.

Chaplaincy service within hospital sites

The chaplaincy service at University Hospitals of Leicester NHS Trust provides religious, spiritual and pastoral care to patients, visitors and staff of all religions and beliefs, including those with no religious belief.

The Chaplaincy team includes Christian, Hindu, Muslim and Sikh Chaplains as well as a non-religious Pastoral Carer. The wider team of volunteers also includes Baha'i, Buddhist, Jewish and Jain representatives.

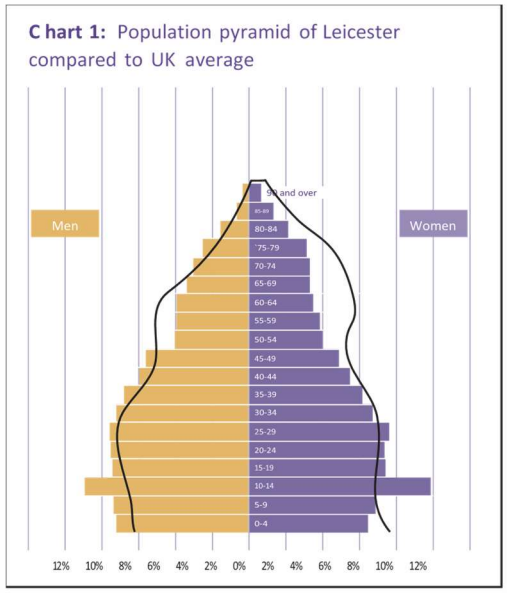
The Chaplaincy service is also provided to Leicestershire Partnership Trust's Community and Mental Health hospitals.

This assessment has also considered that contents of the Chaplaincy annual report highlighting:

- 15,096 - the number of patient contacts by the Chaplaincy team - 12,239 in UHL and 2,857 in LPT
- 883 - UHL patient referrals (12% up on last year - 55% were at Leicester Royal Infirmary)
- 570 - UHL urgent calls for advice or to attend to provide patient support (this is a 19% increase on last year)
- 565 - UHL bedside communion services
- 80- baby funerals conducted by chaplains
- 33 - funerals led by chaplains for patients who have died in hospital with no one to arrange their funeral

4.7 Sex

Cross reference with Age section which contains population profiles for male and females cross referenced with age.
Chart showing men and women with comparison of national population.



http://www.dfes.gov.uk/rsgateway

Charts contained with the age sections above show the population for both men and women across the 3 areas. This chart shows the population for Leicester with the national rate (black line).

Nationally, women live longer than men.

In terms of health needs, we are aware of different health needs between men and women in terms of cancer, long term conditions and screening.

We are aware that there is often higher prevalence of chronic conditions associated with men or women and linked to another protected characteristics. This is exampled with higher prevalence of Cardio Vascular Disease within SE Asian men over the age of 50.

4.8 Sexual Orientation:

National data on lesbian, gay and bisexual (LGB) population varies with official estimates through ONS of 2% compared to an estimate from Stonewall of 5-7%. Local reporting notes that for Leicester this is between 2 and 2.5%.

Source: stonewall.org.uk

Local information on the health needs of LGB groups have been reported through 'A report on the *Health and Social Care needs of Lesbian, Gay and Bisexual people in Leicester Report to the Leicester Public Health Partnership, September 2006 and updated May 2007'.* This report notes specific health and social care needs. The LGB community have greater exposure to the wider determinants of ill health and greater health and social care needs are exhibited in relation to older people, mental health, smoking, alcohol abuse, support in motherhood and child care. In summary this group faces:

- Poorer experiences of hospital and residential care – with poorer respect of individual rights.
- Poorer access to health and social care provision: gay men and women may be less likely to access primary care services than their heterosexual counterparts.
- More likely to experience stigmatisation, discrimination and insensitivity.

Research shows that access to health and social care for the LGB community is problematic and that underlying causes stem from a general lack of awareness of health services to the needs of this group. LGB groups have higher levels of poor mental and physical health than heterosexual counter parts. Bullying, stigmatisation and discrimination contribute to lower educational attainment and low economic status.

There is a higher tendency (when compared to the general population) amongst the LGB population to experience mental health problems including self-harm, attempted suicide and achieved suicide. There is also evidence the evidence that vulnerable men with learning disabilities who have sex with men have a greater exposure to HIV infection

Source: https://www.leicester.gov.uk/media/179049/the-health-and-social-care-needs-of-lesbian-gay-and-bisexual-in-leicester.pdf

4.9 Pregnancy and maternity

Table showing number of births across the area:

UHL TOTAL REGISTERABLE BABIES Data	2013/14 Actual	2014/15 Actual	2015/16 Projected	Total
LRI	5942	6097	6005	18044
LGH	4235	4451	4636	13322
SMBC	224	188	172	584
Total	10401	10736	10812	31949

This data set does not show number of births that were delivered outside the area or at home.
The following data is from Public Health England:

Compared with benchmark: Better | Similar | Worse — Lower | Similar | Higher — Not compared

Indicator	Period	England	Leicester, Leicestershire and Rut...	NHS East Leicestershire And Rutla...	NHS Leicester City CCG	NHS West Leicestershire CCG
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups	2016/17	23.6	31.4*	13.9	56.1	11.9
General fertility rate	2016	62.5	60.8*	60.1	64.2	57.5
Teenage mothers	2016/17	0.7	0.8*	0.6	1.0	0.7
Caesarean section %	2016/17	27.3	-	30.6	27.4	28.6
Multiple births	2016	15.9	16.5*	20.0	16.1	14.1
Low birth weight of all babies	2016	7.3	7.8*	6.0	9.8	6.7
Very low birth weight of all babies	2016	1.22	1.03*	0.56	1.35	1.00
Stillbirth rate	2014 - 16	4.5	5.0*	4.0	5.9	4.6
Admissions of babies under 14 days	2016/17	68.7	47.1*	46.4	43.5	52.4
Breastfeeding initiation	2016/17	74.6	71.5	72.4	73.2	68.4

Summary analysis maternity data sets:

- Birth deliveries for mothers from minority ethnic groups are higher than the England rate – this reflects population data showing higher BME rates within Leicester City. Within Leicester City this rate is 56.1 compared to 11.9 in West Leicestershire
- General fertility rate across LLR (accumulative) is just below the England rate
- Teenage pregnancy rate is higher than the England rate for Leicester City area. This relates to information provided in section 2.5 of this report
- Low birth weights are above the national rate within Leicester City area – rate of 9.8 compared to England rate of 7.3. Close relationship with deprivation and low birth weights
- Still birth rate higher in Leicester City area – rate of 5.9 compared to England rate of 4.5
- Initiation of breastfeeding is generally lower than the national rate across LLR

4.10 Deprivation

Cross reference this section with Health Inequalities section below.

Deprivation data is shown for the 3 areas of LLR. These data sets are from Public Health profiles.

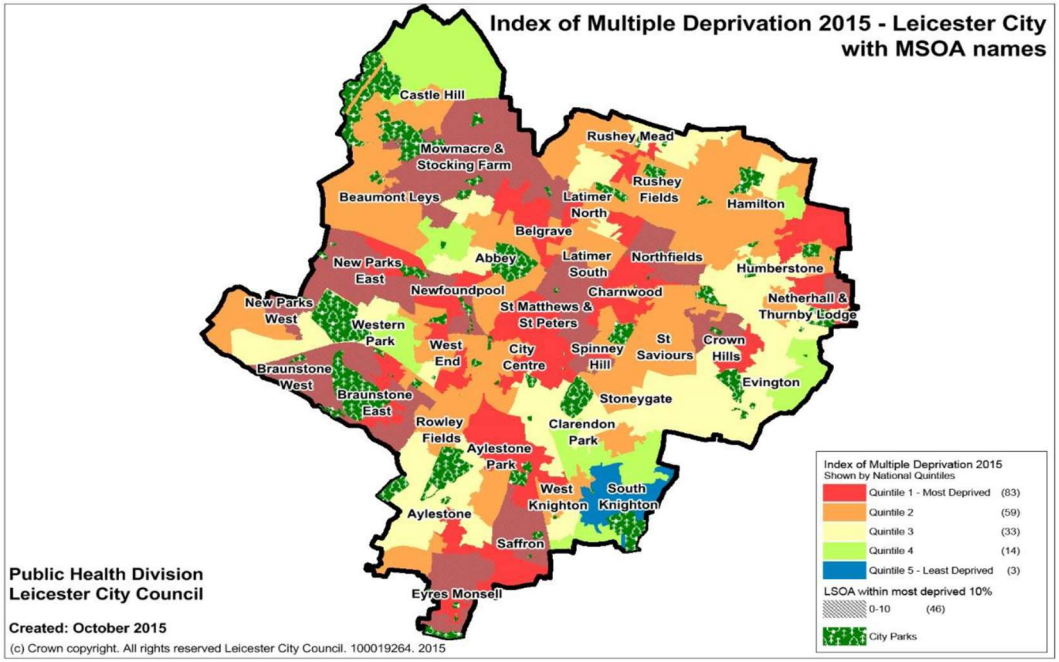
Deprivation data for Leicester:

Compared with benchmark Better Similar Worse Lower Similar Higher Not Compared

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Leicester			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Deprivation score (IMD 2015)	2015	–	-	33.1	-	21.8	42.0		5.7

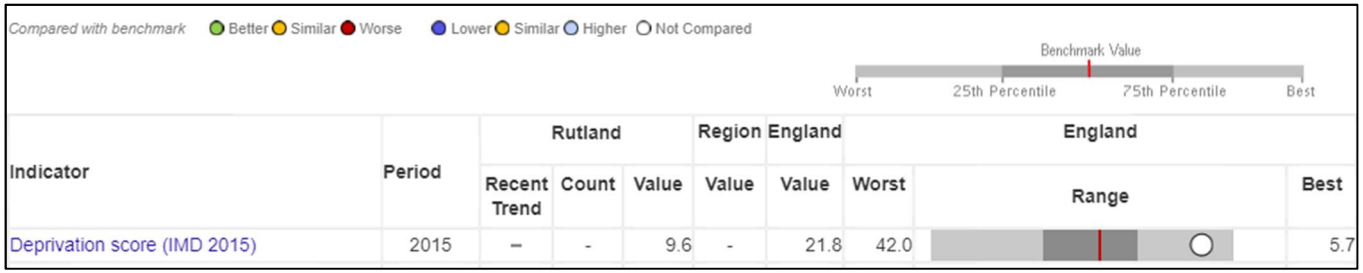
Map showing more details on areas of deprivation for Leicester:



Deprivation data for Leicestershire:

Indicator	Period	Leics			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Deprivation score (IMD 2015)	2015	–	-	12.5	-	21.8	42.0		5.7

Deprivation data for Rutland:



Indicator	Period	Rutland			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Deprivation score (IMD 2015)	2015	–	-	9.6	-	21.8	42.0		5.7

Analysis:

LLR area has variation in terms of deprivation. Across LLR, Leicester City has the highest levels of deprivation and are mostly found in areas close to the city centre. The deprivation map highest areas of deprivation. In terms of deprivation across LLR, there is variation in different parts of the city with more affluent areas being found in Leicestershire and Rutland. Within West Leicestershire and East Leicestershire and Rutland there are pockets of deprivation at lower super output levels.

See section on health inequalities for details on link between health outcomes and deprivation.

4.11 Carers

There are an estimated 100,000 people in LLR that provide some form of unpaid care . The summary tables indicates that across the LLR (at CCG level) the number of carers are line with the national average.

Summary table of carers across the area:

CCG Area within the LLR footprint	Carers	Number and percentage
England rate	Providing 1-19 hours of unpaid care	6.5%
	Providing 20-49 hours of unpaid care	1.4%
	Providing 50 hours or more of unpaid care	2.4%
	% total of people providing unpaid care	10.3%
West Leicestershire CCG including North West Leicestershire, Charnwood and Hinckley and Bosworth	Providing 1-19 hours of unpaid care	7.4%
	Providing 20-49 hours of unpaid care	1.2%
	Providing 50 hours or more of unpaid care	2.1%
	% total of people providing unpaid care	10.3%
East Leicestershire and Rutland	Providing 1-19 hours of unpaid care	7.5%
	Providing 20-49 hours of unpaid care	1.1%
	Providing 50 hours or more of unpaid care	2.0%
	% total of people providing unpaid care	10.6%
Leicester City CCG	Providing 1-19 hours of unpaid care	5.9%
	Providing 20-49 hours of unpaid care	1.6%
	Providing 50 hours or more of unpaid care	2.4%

	% total of people providing unpaid care	9.9%

The health needs of this carers are highlighted in a report by Carers UK – State of Caring 2017.
This report is important in highlighting significant disadvantages faced by carers nationally. The report highlights:

- Caring can have a significant impact on health – both physically and mentally
- GP patient surveys found that 3 in 5 carers have a long term health condition
- Health conditions in 40% of young carers (aged 18-24 years) compared to 29% of non-carers in the age group
- Back and mobility health problems are often acerbated by lack of access to proper lifting equipment and aids
- Carers health often compromised by lack of time to attend medical check-up for their own wellbeing
- 6 out of 10 carers (61%) reported that their physical health has worsened due to caring
- 7 out of 10 carers (70%) reported that their mental health had worsened due to caring
- Worsening health reporting was more prevalent in carers providing more than 50 hours per week
- Carers looking after a disabled child were most likely to suffer from depression – 54%
- Carers report that keeping healthy is more difficult due to difficulty in finding time for exercise and maintaining a healthy diet

Sources: https://www.nomisweb.co.uk/home/profiles.asp
www.carersuk.org/stateofcaring

4.12 Asylum and Refugees

Leicester is a National Asylum Seeker Service (NASS) designated dispersal city. Leicester is host to about 1,000 of the 2,500 asylum seekers resident in the East Midlands. These are mainly from the Middle East or Asia. The city is a designed resettlement area for the Syrian Refugee programme.

Leicester is home to a relative large number of people with refugee status from Zimbabwe, estimated to number 2,000-3,000 people.

Asylum Seeker support services report that Leicester is known to be home to many asylum seekers were their application for refugee status is unsuccessful and illegal immigrants. The details of these people are unknown but could also include people who have been trafficked. Many people in this group survive by sofa surfing and by assistance from local charitable organisations. There could be as many as 3,000 ‘hidden people’ living in the city.

People claiming asylum or with refugee status are recognised as being at risk of have complex health problems. As with the general population, these people experience different physical health conditions and may struggle more with access to services than others.

The most common physical health problems affecting asylum seekers include: communicable diseases, sexual health related needs, chronic diseases, dental disorders, the consequences of injury and torture, psychosomatic disorders, women's health issues and disability issues. To add to this, there is acknowledgement that irregular or undocumented migrants have significant health needs and these are largely hidden from health services.

Compared to the general population, the incidence of mental illness is higher among asylum seekers and refugees. We have used information from the Red Cross and Asylum Matters organisations to support this assessment.

Asylum seekers and Refugees are a vulnerable group which face additional barriers into accessing health service compared to the indigenous population. The issues faces are often complex but include language barriers and understanding of how services work. JSNA data for migrant which includes Asylum seekers notes that in 2011, 1.6% of the total East Midlands population could not speak English well or at all. Additionally in 2011 JSNA noted that 10.8% of primary school children and 8.1% of secondary school children in the East Midlands had a first language that was known or not believed to be English.

4.13 Homelessness

Across LLR the availability and quality of an appropriate home has a substantial impact on health. Issues include decent home standard in the private sector, fuel poverty, overcrowding, homelessness and welfare benefits reforms.

People who don't have a home are described as homeless; this is not just people living on the streets. Homelessness can include people:

- Staying with friends or family
- Staying in a hostel or bed & breakfast accommodation
- Squatting
- At risk of violence or abuse in their home
- People living in poor conditions that affects their health
- Living apart from their family because they don't have a place to live together

There is no single reason why someone can end up without a home. Personal circumstances and wider factors both play their part. Homelessness can be devastating, dangerous and isolating for those who experience it.

Leicester City Council has developed a draft Homelessness Strategy which is currently open for public consultation https://consultations.leicester.gov.uk/communications/homelessness-strategy-2018/

Government street counts show that in 2016, 4134 people sleep rough across England on any given night. This figure rose by 16% from the previous year and has doubled since 2010.

Over £5m a year is invested by the council in services for people who are homeless or threatened with eviction. In 2017, 3000 households were provided with support to help them maintain their current home or find alternative accommodation with an average of 90% of those who asked for help having their homelessness prevented. In the same year the council placed 178 families and 732 singles in temporary accommodation.

Many people who sleep rough will suffer from multiple health conditions, such as mental health problems and drug and alcohol misuse. They are also in greater danger of violence than the general population. On average, homeless people die at just 47 years old. People sleeping on the street are almost 17 times more likely to have been victims of violence. More than one in three people have been deliberately hit or kicked or experienced some form of violence when homeless. Homeless people are 9 times more likely to take their own life than the general population.

Source: Leicester City Council, Homelessness Strategy Consultation.

Leicester City Councils Housing Scrutiny Committee will develop the Homelessness Strategy in order to put into place preventative measures. The Committee has already identified equality issues such as language barriers within their support services.

Further insight into homelessness issues was gained through a research project that was undertaken by the university. The survey was carried out as part of a Connections Week to support the European End Street Homelessness Campaign. About 100 De Montfort University students teamed up with Action Homeless, six other agencies, local councillors and the deputy Mayor to collect data and support rough sleepers in 18 zones of the city from November 6 to 11 2017.

A team of volunteers went into the streets one night to find out just how serious the homelessness problem in Leicester is.

Out of the 93 people surveyed, 55 per cent had been without a home for more than one year and two per cent for more than ten years.

“The aim is to get to know every street homeless person by name, to understand their needs and background and to build up a picture of what support they need to get off the streets,” said Mark Grant, chief executive of Action Homeless, in a report produced following the study.

Source: http://www.dmu.ac.uk/about-dmu/news/2017/november/street-survey-report-reveals-shocking-homelessness-statistics1.aspx

De Montfort University, Leicester

4.14 Veterans and Military families

Cross reference this section with Healthwatch report relating to Military Veterans.

A veteran is someone who has served in the armed forces for at least one day, and there are around 4.5m veterans in the UK. All LLR veterans are entitled to, and have priority access to, NHS hospital care for any condition, as long as it's related to their service, whether or not they receive a war pension. Access to this entitlement is however reliant upon veterans informing their GP about their veteran status. Across LLR veterans access services through the standard referral routes accessible by all.

With regard to armed forces across Leicestershire County and Rutland, of particular note is the decommissioning of RAF Cottesmore which was active between 1938 and 2012 and the subsequent announcement from the Ministry of Defence that Army troops would be deployed to Kendrew Barracks on the former RAF Cottesmore site effective from July 2012. It is situated at Cottesmore is located in Rutland situated between Leicester and Peterborough. The Kendrew Barracks is home to Second Battalion The Royal Anglian Regiment NS RHW 7 Regiment The Royal Logistics Corps.

St George's Barracks North Luffenham is situated in a rural location between the villages of Edith Weston and North Luffenham close to the south shore of Rutland Water. It is home to 16 Regiment Royal Artillery, undertaking rolling deployments to Afghanistan and the Falkland Islands. Both barracks fall within the boundary area for NHS East Leicestershire and Rutland CCG.

The health needs of military families are documented within a 2017 report – Meeting the public health needs of the armed forces produced by Public Health England with the Ministry of Defence. In general, the health of the military population is good compared with the general population, due to the expected physical fitness required to join the armed forces, social support networks available, and access to health care and employment. The report notes that Service families often face additional pressures on family life resulting from separation from loved ones due to deployment on exercises and operations. They also tend to be more mobile than families in the general population, moving every two years, with moves sometimes unplanned and at short notice. Service families experience living away from their wider family and significant periods of separation which can lead to social isolation and additional and sudden caring responsibilities, along with the worry of illness, injury and death during deployments.

Key information about Armed Forces:

Source: http://www.army.mod.uk/documents/general/LO-NorthLuffenham_and_Cottesmore-Aug14.pdf

https://www.local.gov.uk/sites/default/files/documents/1.17%20LAs%20Mythbuster%20resource_v06.pdf

5.0 Health Inequalities

Health is determined by a complex mix of factors including income, housing and employment, lifestyles and access to health care and other services. Significant inequalities in health exist between individuals and different groups in society. In particular, there is a 'social gradient' in health; neighbourhood areas with higher levels of income deprivation typically have lower life expectancy and disability-free life expectancy. This relationship (known as the 'Marmot curve') formed an important part of the independent and influential report on health inequalities, (the

Marmot Review). It can include belonging to a minority group or being socially excluded from mainstream society. Chances for good health are not equally distributed in society and this causes health inequalities and a range of factors influence an individual's chances of leading a flourishing, healthy life.

Marmot's (2010) concern was with the 'social determinants' of ill-health or the 'causes' of health inequalities – those fundamental social and economic conditions which have been shown to have an impact on how healthy a person will be during the course of their life. This includes the conditions in which people are born, grow, live, work, education, these complex and wide-ranging network of factors, influence health outcomes for disadvantaged groups of people, compared with the rest of the population. Therefore, if not taken into consideration when planning health services, the social determinants of health act as barriers to addressing health disparities.

The intention of the proposed model, Better Care Together, is to improve access for diverse needs and navigability for patients, to reduce health inequalities, remove unnecessary duplication and significantly enhance patients' experiences.

It is important to note that socio economic factors such as deprivation and housing are the root cause of many issues seen as health inequalities but healthcare services and that health inequalities can only be addressed through other government departments and joint working strategies.

Socio economic factors play the key part in how healthy a life people lead, however there is some crossover, for example; high prevalence on unemployment within Black and Minority Ethnic (BME) communities and people going through gender reassignment, disabled people living on benefits, low income for lone parents and people with caring responsibilities often lead to poor housing conditions and poor diets. Considering the proposals these groups will also be less likely to own their own transport.

Socio-economic duties were removed as a specific duty from the Equality Act 2010 during its progression through Parliament, however this assessment will consider the impacts on people living in deprived areas or in poverty as there is a clear link between socio economic factors and health outcomes. There is also a duty on CCGs to reduce health inequalities.

Socio-economic factors are known to be powerful determinants of health; life expectancy tends to be shorter in areas of deprivation and relative poverty. Whilst poorer people make more substantial use of primary care and emergency departments, they make lower use of screening and immunisations as well as other preventative services, often resulting in poorer general health. There is a well-documented link between social deprivation and higher admission rates in children for paediatric care; A report for NHS Quality Improvement Scotland in 2004 suggests that deprivation impacts on a range of issues including the number of children admitted to hospital for unintentional injury, asthma and diabetes.

Further evidence for a Mayor of London study in 2007 supported this view, pointing out that 'children born into poverty are more likely than their better-off neighbours' to have a parent who smokes and have poor nutrition, which are both key determinants of health.

The lack of preventative care can be a key cause of deprived groups' over-representation in the use of acute care and through Emergency care. There is convincing evidence to suggest that people from deprived communities have a high susceptibility to conditions requiring emergency complex surgery and emergency complex medicine, and in particular, vascular care.

For example, there are marked inequalities in smoking rates between the most affluent who smoke least, and the least affluent, who are most likely to smoke. Smoking is one of the major causes of cardiovascular diseases, including Coronary Heart Disease, according to the British Heart Foundation; smokers are almost twice as likely to have a heart attack as those who have never smoked.

Obesity, which is associated with cardiovascular disease, stroke and diabetes, is also a frequent condition amongst poorer demographic groups. This is partly because residents have less financial freedom with their food budget and more limited access to physical activity at safe recreational spaces or leisure centres, Sport England suggests that of those that regularly participate in active recreation, only 15% are from the lowest socio-economic groups compared with 26% from the highest.

National review into maternity services - The Better Births Improving outcomes of maternity services in England – A Five Year Forward View for maternity care was published by NHS England in 2016. The report noted inequalities and evidence of outcomes for babies. These include poorer outcomes linked to deprivation. Babies whose mothers live in poverty have a 57% higher risk of perinatal mortality.

Sources: https://www.gov.uk/government/publications/health-profile-for-england/chapter-5-inequality-in-health
https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

JSNA work across LLR provides health and wellbeing data on the local population which help commissioners to identify health inequalities.

Key themes relating to health inequalities include:

Life expectancy:

Across the LLR area, differences exist for male and female, the average life expectancy in Leicester is 77.3 years for males and 81.9 years for females. Differences exist across the LLR area with average life expectancy of 81 years for males and 84.7 years for females.

LLR Better Care Together programme has drawn on this evidence within their Pre Consultation Business Plan. This document evidences that the differences in life expectancy is complex and impacted by deprivation, lifestyle and wider determinants of health.

Health outcome variations:

Health outcomes vary across the LLR area with variation in the treatments and services received depending on where patients live and access services. For example patients with diabetes living in Leicester City are more likely to receive the 3 recommended treatments (per NICE guidance) (43.8% of patients) compared to patients in Rutland (41.9%)

Ill health and disease:

Mortality rates vary across the LLR area directly linked to ill health and disease.

- Cardiovascular disease
- Respiratory disease
- Cancer
- Liver disease

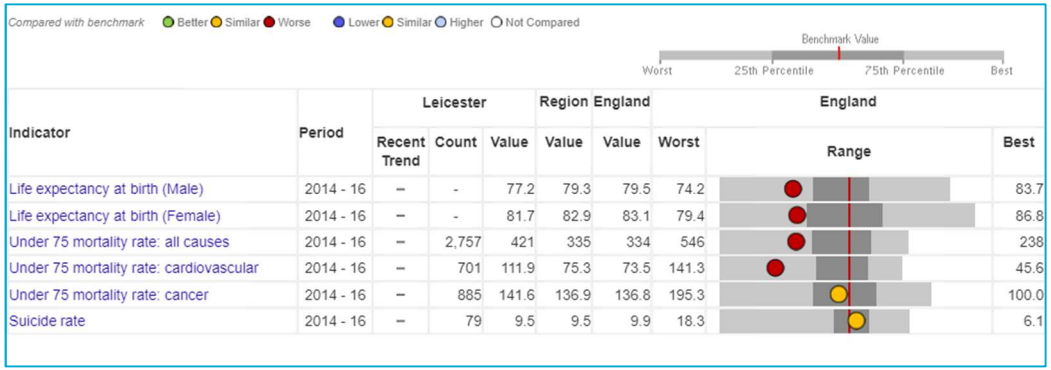
The above diseases are closely linked to lifestyle behaviours with 50% of stroke, 65% of chronic heart disease, 70% of COPD (lung disease) and 80% of lung cancer are due to behaviour risk. See section below on information relating to cancer.

5.1 Other health related data – from Public Health England – fingertip data

Data has been sought for each of the 3 areas within the LLR area. This section provides supplementary evidence from Public Health data sets. Data shown is latest available at 19/7/2018. Source: https://fingertips.phe.org.uk/profile/health-profiles/

Tables showing life expectancy and mortality rates:

Table 1: Leicester

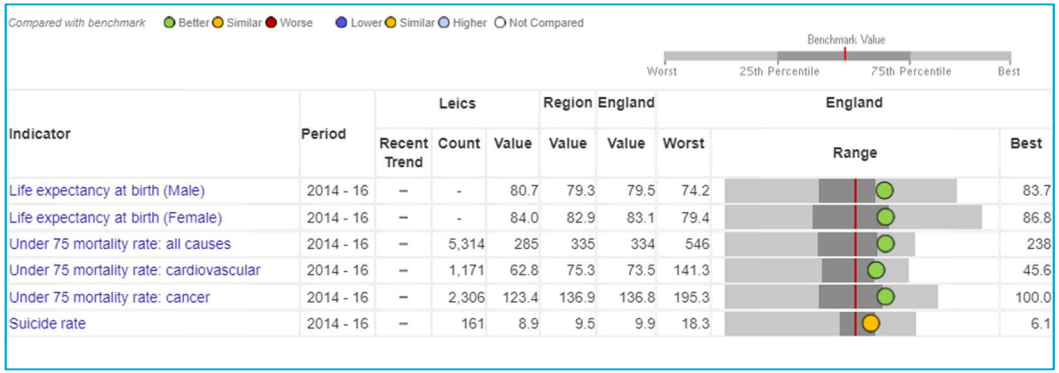


Compared with benchmark: Better, Similar, Worse | Lower, Similar, Higher, Not Compared

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

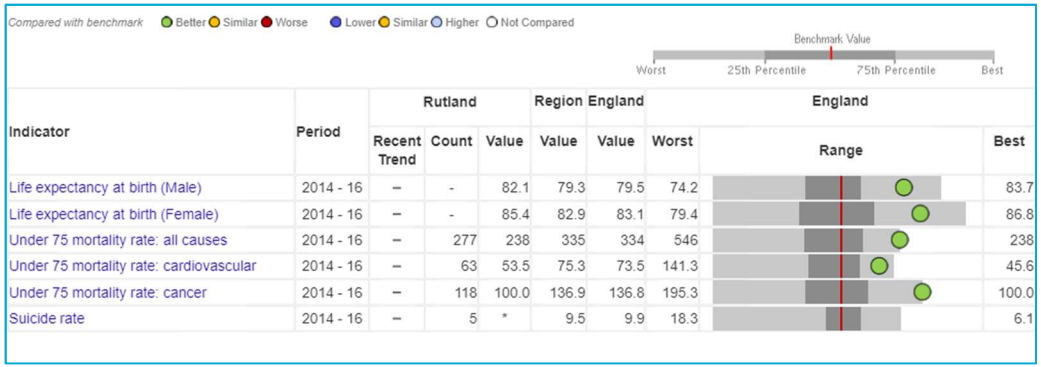
Indicator	Period	Leicester			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Life expectancy at birth (Male)	2014 - 16	–	-	77.2	79.3	79.5	74.2		83.7
Life expectancy at birth (Female)	2014 - 16	–	-	81.7	82.9	83.1	79.4		86.8
Under 75 mortality rate: all causes	2014 - 16	–	2,757	421	335	334	546		238
Under 75 mortality rate: cardiovascular	2014 - 16	–	701	111.9	75.3	73.5	141.3		45.6
Under 75 mortality rate: cancer	2014 - 16	–	885	141.6	136.9	136.8	195.3		100.0
Suicide rate	2014 - 16	–	79	9.5	9.5	9.9	18.3		6.1

Table 2: Leicestershire (excludes Leicester)



Indicator	Period	Leics			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Life expectancy at birth (Male)	2014 - 16	–	-	80.7	79.3	79.5	74.2		83.7
Life expectancy at birth (Female)	2014 - 16	–	-	84.0	82.9	83.1	79.4		86.8
Under 75 mortality rate: all causes	2014 - 16	–	5,314	285	335	334	546		238
Under 75 mortality rate: cardiovascular	2014 - 16	–	1,171	62.8	75.3	73.5	141.3		45.6
Under 75 mortality rate: cancer	2014 - 16	–	2,306	123.4	136.9	136.8	195.3		100.0
Suicide rate	2014 - 16	–	161	8.9	9.5	9.9	18.3		6.1

Table 3: Rutland:

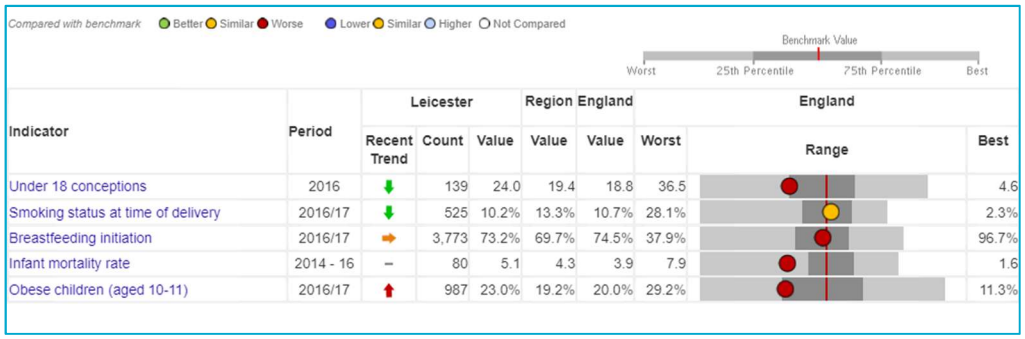


Indicator	Period	Rutland			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Life expectancy at birth (Male)	2014 - 16	–	-	82.1	79.3	79.5	74.2		83.7
Life expectancy at birth (Female)	2014 - 16	–	-	85.4	82.9	83.1	79.4		86.8
Under 75 mortality rate: all causes	2014 - 16	–	277	238	335	334	546		238
Under 75 mortality rate: cardiovascular	2014 - 16	–	63	53.5	75.3	73.5	141.3		45.6
Under 75 mortality rate: cancer	2014 - 16	–	118	100.0	136.9	136.8	195.3		100.0
Suicide rate	2014 - 16	–	5	*	9.5	9.9	18.3		6.1

Analysis of under 75 mortality causes: Leicestershire and Rutland areas performs better than England rate for 4 major causes of death. Causes mirror that of England with highest cause being Cancer, followed by Cardio-vascular diseases, then respiratory disease followed by Liver disease. Leicester data indicates that rates are higher than England rate for all causes of death, cardio vascular and cancer. This is closely aligned to deprivation levels.

Child health:

Table showing child health data for Leicester:

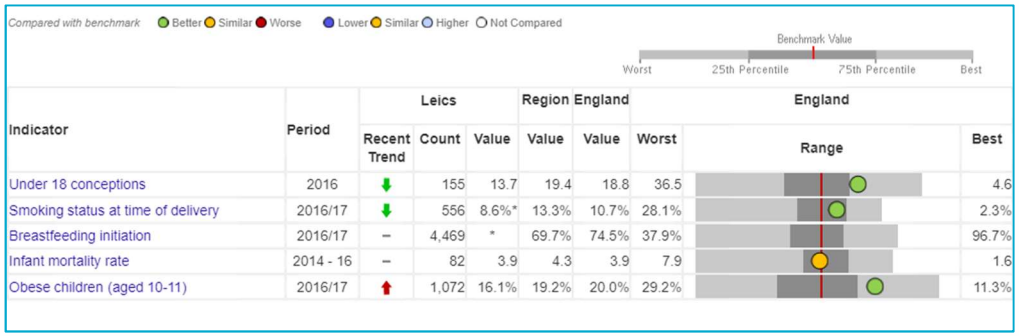


Compared with benchmark: Better / Similar / Worse — Lower / Similar / Higher / Not Compared

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Leicester			Region England	England	England		England
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 18 conceptions	2016	↓	139	24.0	19.4	18.8	36.5		4.6
Smoking status at time of delivery	2016/17	↓	525	10.2%	13.3%	10.7%	28.1%		2.3%
Breastfeeding initiation	2016/17	→	3,773	73.2%	69.7%	74.5%	37.9%		96.7%
Infant mortality rate	2014 - 16	–	80	5.1	4.3	3.9	7.9		1.6
Obese children (aged 10-11)	2016/17	↑	987	23.0%	19.2%	20.0%	29.2%		11.3%

Table showing child health data for Leicestershire:

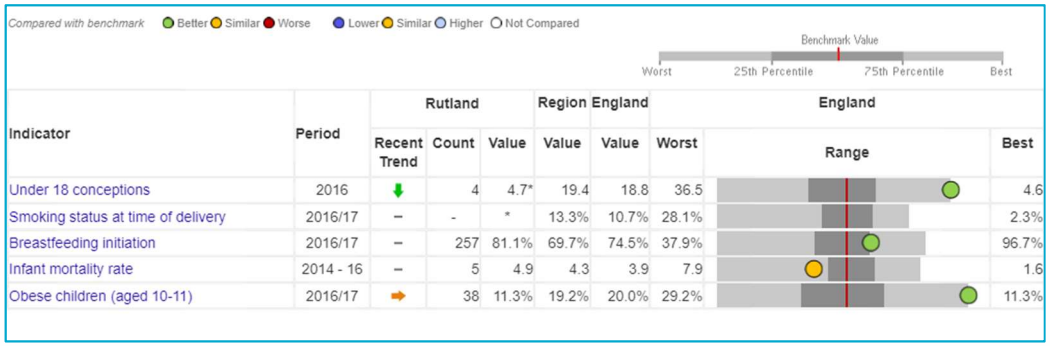


Compared with benchmark: Better / Similar / Worse — Lower / Similar / Higher / Not Compared

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Leics			Region England	England	England		England
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 18 conceptions	2016	↓	155	13.7	19.4	18.8	36.5		4.6
Smoking status at time of delivery	2016/17	↓	556	8.6%*	13.3%	10.7%	28.1%		2.3%
Breastfeeding initiation	2016/17	–	4,469	*	69.7%	74.5%	37.9%		96.7%
Infant mortality rate	2014 - 16	–	82	3.9	4.3	3.9	7.9		1.6
Obese children (aged 10-11)	2016/17	↑	1,072	16.1%	19.2%	20.0%	29.2%		11.3%

Table showing child health data for Rutland:



Indicator	Period	Rutland			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 18 conceptions	2016	↓	4	4.7*	19.4	18.8	36.5		4.6
Smoking status at time of delivery	2016/17	–	-	*	13.3%	10.7%	28.1%		2.3%
Breastfeeding initiation	2016/17	–	257	81.1%	69.7%	74.5%	37.9%		96.7%
Infant mortality rate	2014 - 16	–	5	4.9	4.3	3.9	7.9		1.6
Obese children (aged 10-11)	2016/17	→	38	11.3%	19.2%	20.0%	29.2%		11.3%

Analysis: The above data tables shows that child health outcomes vary across the LLR area. Poorer health outcomes are experienced in Leicester City area compared to Leicestershire and Rutland. Leicestershire and Rutland tend to fare favourably compared to Leicester City with the exception of infant mortality rate.

Cancer:

There is variation in the survival rates of cancer across LLR. In Leicester City the rate is 65.9% compared to East Leicestershire and Rutland rate of 70.2% after 1 year. Cancer is a major cause of premature mortality rates across LLR. Early detection has a direct impact on survival rates. This is exampled with the survival rates of colon cancer. If detected early (at stage 1) 9 in 10 people will survive after 5 years compared to late detection (stage 4) where only 1 in 10 will survive beyond 5 years. Similar rates exist for rectal, ovarian and lung cancers.

Mental Health:

Across LLR, there are differences in mental health needs that relate to different groups. Some of these differences are directly comparable to the variation in demographics for the area. Leicester City has higher levels of people with psychosis and depression, whilst West Leicestershire and East Leicestershire and Rutland areas have higher levels of dementia. Supporting JSNA data indicates that a significantly higher proportion of population registered with a mental illness than in England or the East Midlands, and the trend is worsening. By 2011-2030 there is likely to be a 16% increase in 18-64 year olds with a common mental health disease and 7% increase in those with two or more diseases

Diabetes:

Across LLR, a greater proportion of the population 17 years and older diagnosed with diabetes than nationally (7% vs. 5.4%). Estimates of prevalence are higher at 10% in the city, and predicted to increase to 12.8% (some 33,000 people) by 2025. Prevalence is around four times

higher in the South Asian population than in the white population and tends to develop at a younger age. A key indicator of clinical management, HbA1c , is statistically significantly worse than in comparator areas and in England as a whole.

Sexual Health:
Sexual health within LLR is similar to the national picture with rising numbers of sexually transmitted infections. While Chlamydia is the most commonly sexually transmitted infection. Leicester and Leicestershire have the lowest diagnosed rate of Chlamydia infection per 100,000 population for 15 – 24 year olds in the East Midlands.

Nearly 700 people with HIV infection were seen In 2010 for statutory medical HIV related care - a prevalence of 3.38 per 1000 population, the highest in the East Midlands.

Despite huge progress over ten years, conceptions in under 18 year olds in Leicester in 2010, were statistically significantly higher than the conception rate for England (44 vs. 35 per 1000 15 – 17 year old females).

Smoking and Tobacco:
LLR despite huge progress over ten years, conceptions in under 18 year olds in Leicester in 2010, were statistically significantly higher than the conception rate for England (44 vs. 35 per 1000 15 – 17 year old females).

Obesity:
Across LLR, a similar proportion of adults is estimated to be obese than in England generally, around 24%. Levels of overweight and obesity are comparable with the England average at reception, 22.9%, and year 6, 33.1%. Only a quarter of Leicester adults eat the recommended 5-A-Day fruit and vegetables. 57% of adults report no physical activity in previous 28 days. Obesity and overweight is a contributor to CVD, cancer and poorer mental health.

Alcohol and substance mis-use:
Across LLR, there are lower levels of alcohol consumption but statistically significant higher harm than nationally, shown in hospital admissions for both alcohol specific and related disease and alcohol related crime, though trend is improving. Specific Needs Assessment undertaken in 2011/12 to inform detailed commissioning.

Substance misuse is just below national levels, but higher rate of hospital admissions and significant contribution to crime. More problematic drug users than nationally. Specific Needs Assessment undertaken in 2011/12 to inform detailed commissioning.

Child and Young People's Health:
Across LLR there has been significant improvement in a range of areas but Leicester is below, or worse than, the England average for infant mortality, child mortality rate, children achieving a good level of development at age 5, GCSE achievement, those not in education,

employment or training, children living in poverty (aged under 16), children who are obese, participation of at least 3 hours of sport / PE, teenage conception rate, children's tooth decay, hospital admissions due to injury, hospital admissions as a result of self harm.
Cross reference to section on Pregnancy and Maternity. This section contains data on still births and low birth rates.

End of life:
Across LLR, in 2011, nearly 42% of people who died in Leicester, did so on in their home or care/residential home. The proportion of people dying at home increases with increasing age. Palliative care prevalence in Leicester is 0.09%, less than half the national rate (0.22%) in 2010-11.

5.2 Evaluation of data sets:

- Collation of the data has used both Public Health Profiles, JSNA and ONS
- The majority of data sets is not current however is the latest available
- Data at LLR level is difficult to find as the data has been collated at Local Authority levels – not at a STP level

6.0 University Hospitals of Leicester NHS Trust Performance Data

The following summary table shows target and current performance data:

Performance indicator	Target	University Hospitals of Leicester NHS Trust performance	England comparator
A&E : The number of attendances admitted, transferred or discharged within 4 hours	95%	79.84% (September 2016)	90.7% (June 2018)
Referral to Treatment (RTT) RTT waiting times – admitted RTT waiting times – non admitted RTT delivery in all specialities 6 week diagnostic test waiting times	92% 91.99% 97.2% 0% <1%	91.6% 90% 95% 1% 1.1%	92.2% 92.2% 97.6% Not available Not available
Ambulance response times for calls C1 – critical life threatening	8 minutes	67.7%	Average 7.38 mins

Ambulance response times for calls C2 – emergency calls	18 minutes	56.5% Source: East Midlands Ambulance Annual report	Data not found for new indicator.
Ambulance hand over Measure of the percentage of handover delays between 30 and 60 minutes and over 60 minutes	0% > 60 minutes	Ambulance handover > 30 mins and < 60 (Year to Date (YTD)) 9% Ambulance Handover > 60 mins (YTD) 15% *Feb 18 - Ambulance Handover 60+ minute. Performance was 10% - worst performance since January 2017	The increase of ambulance delays is reflective of increased and sustained pressure across the emergency care pathway and is replicated across the region.

Source: https://www.nhs.uk/service-search/Performance/Highlights

Analysis: Key Performance data highlights across that UHL performance is not meeting key national standards.

The Better Care Together Programme have identified that performance is failing or is at risk of not meeting national standards.

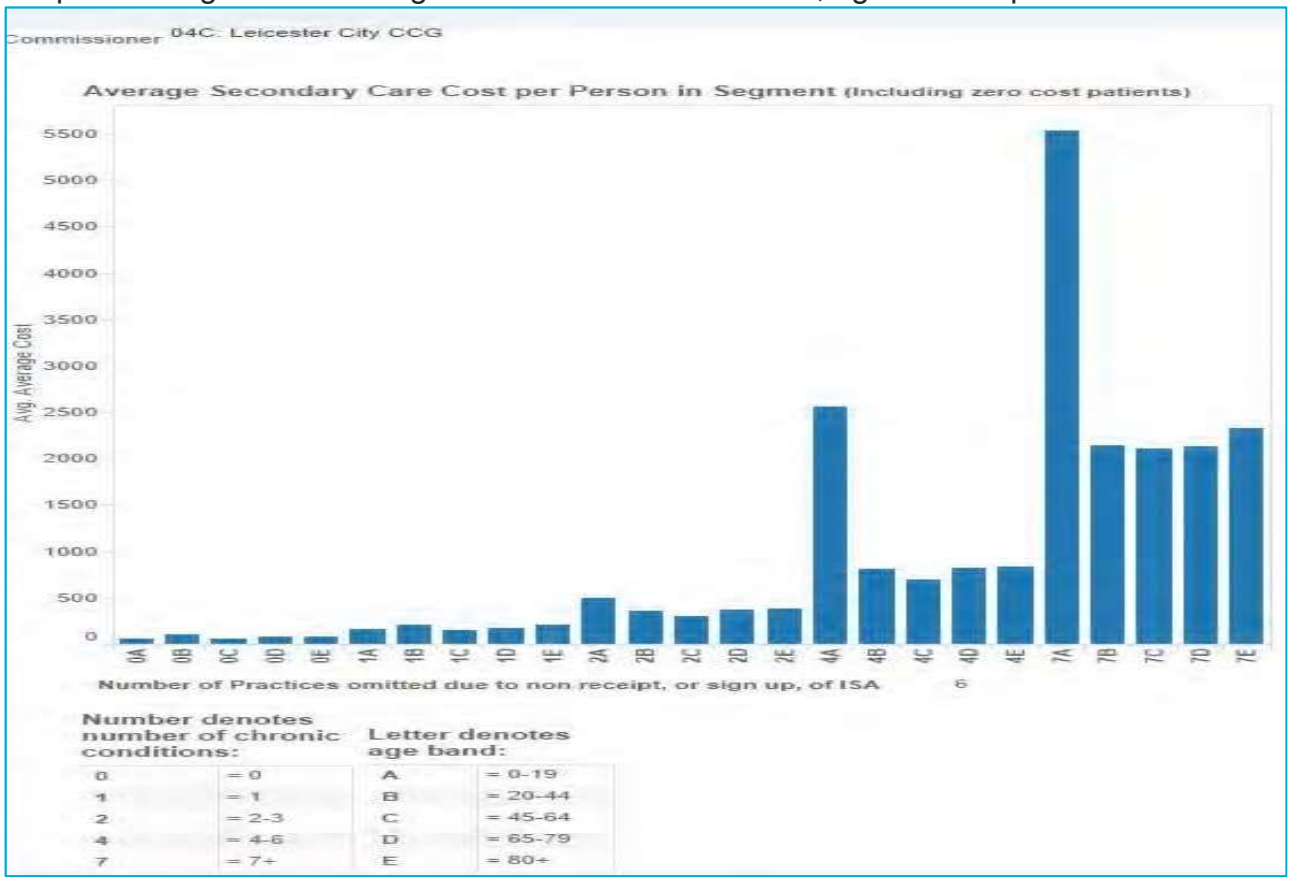
7.0 Patients using the hospital:

Data on patients using hospital services use a system called John Hopkins Adjusted Clinical ACG to analyse cohorts of patients to understand their services.

This data helps identify cohorts of patients that may be impacted by the proposal.

Data analysis shows a direct relationship between age, chronic conditions and higher levels of hospital use and subsequent costs.

Graph showing costs showing link with chronic conditions, age and hospital costs:



Analysis of this shows:

- the highest costs are from 0-19 years with 7 or more chronic conditions
- the second highest costs for ages 0-19 years with 4 to 6 chronic conditions
- the third highest costs across 80 years plus with 7 chronic conditions
- there is an association with low level of costs and low number of chronic conditions
- analysis carried out by the LLR STP notes that age alone is not the key factor is usage but that multi-morbidity is the driving factor

Further analysis by the LLR STP notes:

- multi-morbidity occurs across the whole population

- multi-morbidity is the main factor is usage and high cost of secondary care resources
- small numbers of individuals account for a disproportionate amount of resource use bed

8.0 Travel / Transport analysis – acute proposal

Current movement of patients and staff using public transport is currently supported by a 'hospital hopper' bus service that runs between the 3 sites, this is a public transport service that covers multiple stops across the city. Patients can buy a single or day ticket on the bus, or get a Hopper Smartcard for more regular travel. UHL staff travel free on production of their ID card and local council concessionary permits are valid on the hopper service.

UHL provide comprehensive information on their websites on travel advice with maps showing main routes and parking facilities.

Car parking charges apply across the hospital car parks and are currently £6 per day. Weekly tickets are available for £16.50, Monthly tickets £55 with saver cards also available. Car parking fees can be reimbursed for patients receiving qualifying benefits such as income support, pension credit or an NHS Tax credit exemption certificate.

This assessment has calculated the following travel distances:

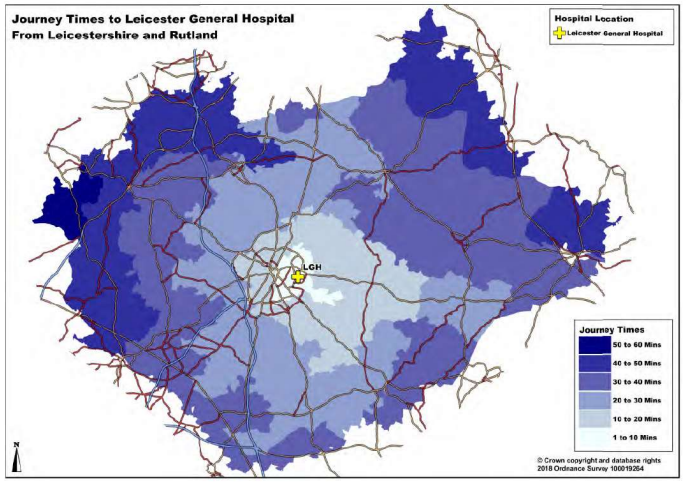
- Travel distance between LGH to LRI = 3.6miles
- Travel distance between LGH and GH = 7.6 miles
- Travel distance between LRI and GH = 3.2 miles

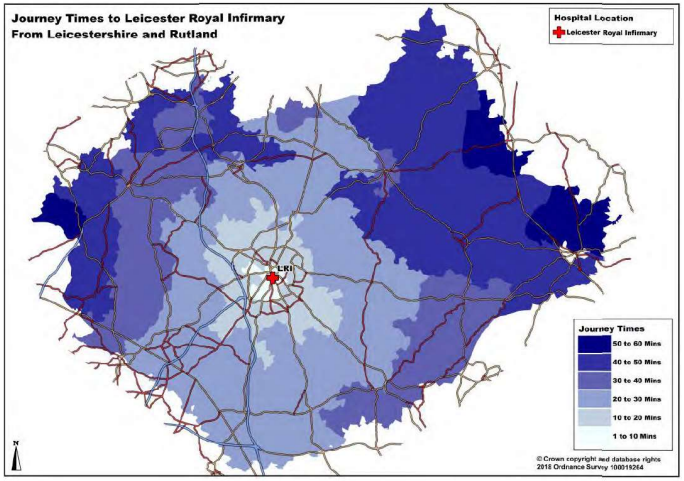
These distances were calculated using the online AA route master as part of this assessment.

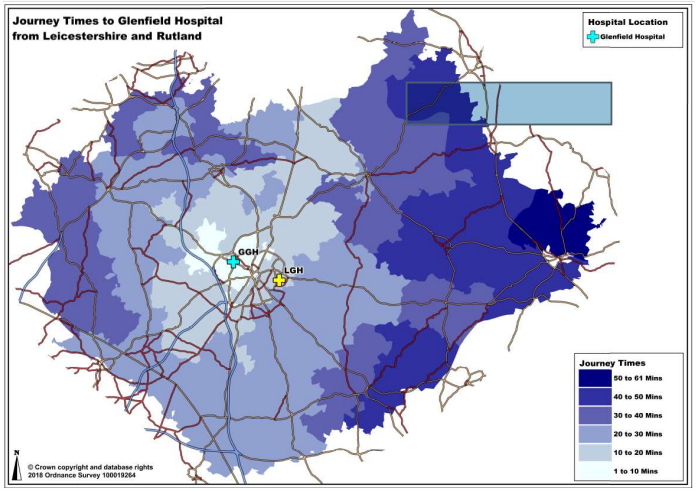
A Travel Impact Assessment (TIA) has been carried out to identify the impact that the proposed change will have on different areas. MapInfo was used, which is a Geographical Information System. This included travel by car and public transport. The TIA was carried by Planning, Development and Transportation Department Leicester City Council. In support of this equality impact assessment, TIA map reports were provided.

The travel analysis took main arterial road networks and postcode distances into account.

The TIA is visually represented within the following maps:



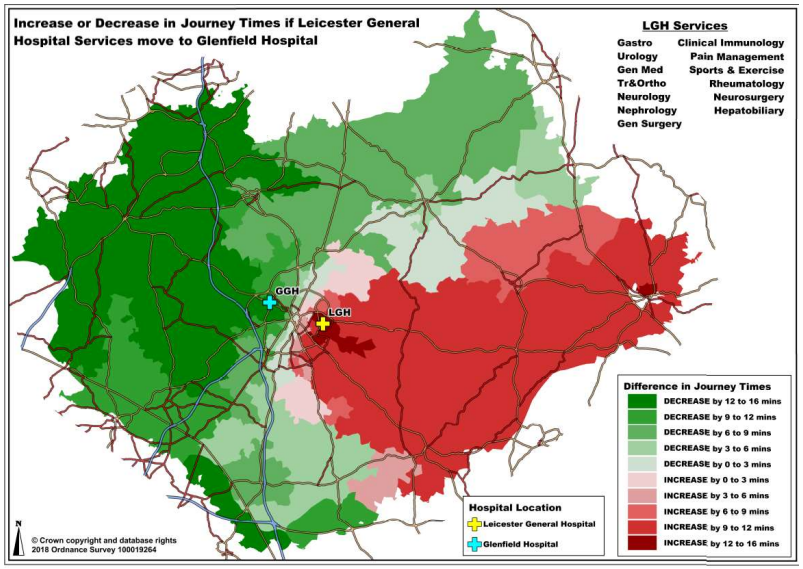


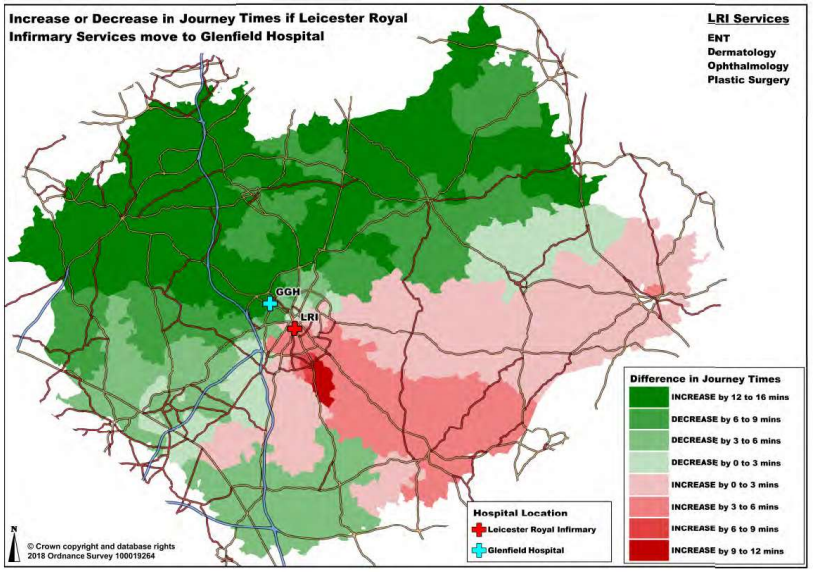


Darker shades of blue denotes areas where patients will experience longer travel times.

Leicester City Council confirmed that travel times for public transport were the same as car journey times.

Map showing differences in journey times for moving acute services to GH:





8.1 Key findings from the TIA:

The key impact of moving services between UHL's three main hospitals is predicted as being;

- 30% of LLR patients will have an increased travel journey when travelling by car.
- Access by public transport is generally improved but will be an issue for a small number of postcodes where public transport is poorly served.
- The increase in travel time to travel to acute service is in general less than 15 minutes. TIA indicates that 16 minutes is the maximum travel increase.
- More UHL planned care services will be delivered closer to people's homes in community hospitals
- Additional stakeholder and engagement feedback within the Better Care Together work, highlights that the majority of people think that reducing waiting times and specialists is more important to them compared to an increase in travel time
- The Pre Consultation Business Case notes that travel issues may be more significant for older groups and some ethnic groups. This may be due to access to a car. This would be further examined within a formal consultation.
- For some postcodes where increased travel exceeds 30 mins (LE15 6, LE15 7, LE15 8, LE15 9, LE16 8) could be mitigated by reduced travel by accessing care in Peterborough and Stamford and Kettering. Potential activity from these postcodes per annual total 1208 journeys. (see Appendix E showing postcodes materially impacted)

The TIA analysed the change in journey times because of service reconfiguration. The journey time data was used to identify the difference between the journey time to the hospital currently providing the service and the one that it has been proposed to be moved to. The journey times analysed were by car and public transport.

The above information has been collated from TIA report and associated maps together with information within the Pre Consultation Business Case. The current TIA information does not include any travel analysis for the proposed change of moving the Midwife Led Birthing Unit from St Marys to Leicester or Peterborough. Also the assessment information did not include any assessment of travel time through the ambulance service or Patient Transport System. This assessment notes that there are some areas where understanding could be improved and these will be noted within the recommendations sections of this report.

8.2 Travel / Transport Analysis for St Marys hospital to Leicester General Hospital

As part of the work to review maternity services and the potential impacts on travel the Better Care Together Programme carried out a Travel Impact Analysis.

This analysed travel time / distance by car and public transport for travel to LGH for people that would have previously attended St Mary's standalone Midwife Led Birthing Unit.

Postcode tables and travel information can be found in Appendix D.

Summary of impact for travel increase of option 1 and option 2

Option	***Impacted inpatient stays at St Mary's birthing unit***	***Impacted inpatient stays at LGH***	***Impacted outpatient appointments at LGH***	***Overall impacted activity***
Option 1 MLU at LGH	230 midwifery	9 neonatal 1068 obstetrics	215 neonatal 977 obstetrics	2,499
Option 2 No standalone MLU	230 midwifery	9 neonatal 1068 obstetrics 601 Midwifery	215 neonatal 977 obstetrics 146 Midwifery	3,246

8.3 Summary of findings include:

- During appraising options, the travel analysis indicated that the impact of option 1 is lower than the overall impact of option 2 on the materially negatively impacted postcodes.
- Option 2 would see more women having to travel further for services, however this makes the assumption that all women who use the LGH midwifery services co-located with obstetrics would use or be able to use a standalone midwifery service.
- The following postcodes will be negatively impacted with increased travel and distance and time by car to LGH: LE13 1, LE14 2,LE14 4, NG 33 5. The increase in travel time for these varies between 31 minutes and 24 minutes of additional time. These postcodes are also negatively impacted by increase of cost associated with increased distance
- The following postcodes will be negatively impacted upon with increased travel times when travelling by public transport: LE13 0, LE13 1, LE15 6 and LE7. Additional times vary from these postcodes from 15 to 80 minutes. LE131 has an additional travel time of 80 minutes
- The following post codes will be negatively impacted with increase travel distance and time to LRI: LE13 1, LE14 2, LE14 4, and NG33 5. These postcodes will be most impacted negatively in terms of increased travel costs.
- The following postcodes will be negatively impacted with increased costs of public transport for travel to LRI: LE 14 4, LE13 1, NG 33 5
- Mitigation findings include:
    - Travel analysis report notes that some women using the unit at St Mary's may choose to access maternity services (Midwife Led Unit) outside of the area.
    - Option for home births (although this assessment notes that this may not be feasible for some women)
    - Obstetrics and midwifery services: the provision of a new specific women's site at the LRI may be attractive
    - Specific short stay / drop off near the women's hospital for women in labour

All antenatal and postnatal services will continue to be delivered locally so the negative impact, in the case of midwifery services, is related to giving birth only where travel to a hospital is required.

8.4 Further undertaken for this assessment has found:

The travel analysis has highlighted key postcodes that will be disadvantaged by increased travel. Demographic background information has been collated on these postcodes to assess if the level of disadvantage would be significant due to other factors such as deprivation, level of health and demographics. In summary this information shows:

- Postcodes of LE13 and LE14: These postcodes are in Melton Mowbray and surrounding rural areas. The population is predominantly white British (93.1% LE13 and 97.1% LE14). Both areas are affluent and census data shows that majority of population report very good or good health
- Postcode of NG33: This postcode area is located in Grantham and surrounding rural areas. The population rate for this area is 9709. The population are mainly white British (97.6%) and relatively affluent. This area comes under South West Lincolnshire CCG but borders Leicestershire
- The assessment notes that impacts on these postcodes will have further travel but are not further negatively impacted by factors relating to deprivation or protected characteristics
- In relation of protected groups – no significant vulnerable communities are noted within most impacted postcodes – for example – there are no known Traveller sites, significant BME communities or deprived communities living in this area. This general demographic does not identify individual cases were people may be negatively impacted – and as such this should be addressed within the public consultation work

9.0 Workforce issues

UHL employees approximately 15,000 staff.

The current situation of staff working across three sites and staff shortages means that staff resources are spread too thin. Nationally there is a shortage of key workforce groups – including doctors, nurses, midwives, emergency medicine consultants, non consultant anaesthetists, paediatricians, general surgeons and obstetricians and gynaecologists.

Serious concern has been raised within the Quality Surveillance Programme visit to neonatal services due to insufficient consultant cover across the split site.

UHL struggle to meet staffing standards for consultant obstetricians being present for 60 hours when delivering more than 6000 deliveries.

The current staff vacancy rates are 7.5% and includes nurse vacancy rate of between 12% and 15% throughout the year. Medical vacancy rate is between 5% and 6% with key gap in neonatal. Women's and Children's services have the largest vacancy rate for junior doctors. UHL spend between £5 – 6 million on non-contracted pay bill.

Within the proposal there is no plan to reduce the workforce, however as the system changes takes place, staff roles may change.

The proposals for the reconfiguration of acute and maternity services links to the UHL strategic workforce plan. This aims of this plan is to:

1. Ensure capacity and capability to reflect changing demographic needs and changing service delivery models.

2. Address challenges in supply and new ways of working across different organisations including flexible working.
3. Maximise opportunities through apprenticeship schemes
4. For UHL to be an employer of choice – with career development pathways, high quality training and development
5. Address short term crisis such as winter of 2018/19 to better plan for frail / co-morbidities and reduce escalating pay-bill costs.

This assessment acknowledges that the strategy impacts on the workforce and patients in several ways linking with the equality agenda.

These include:

- Meeting complex needs of patients with protected characteristics
- Young people provided with opportunities through apprenticeship schemes
- Flexible ways of working benefitting staff that are carers and workers with caring responsibilities
- Training opportunities will help tackle traditional barriers faced by particular groups – such as Black and Minority Ethnic groups and the gender pay gap

The Better Care Together Programme affects staff through the movement of acute services and the closure of St Mary's Midwife Led Birthing Unit at Melton Mowbray.

This assessment recognises that in addition to hospital staff, the proposals may also indirectly affect other staff groups such as Ambulance staff, Community Midwives and Volunteers working within the system.

10.0 Clinical assurance:

The proposals within the Better Care Together Programme has clinical oversight through the East Midlands Clinical Senate and the LLR Clinical Leadership Group.

The Clinical Leadership Group comprises of medical and nursing clinicians, public health and social care representatives, G.P's from both Primary Care and Secondary Care. The group are responsible to giving assurance over the quality and safety of proposals together with oversight of engagement work to ensure that proposals meet the interest of patients and the public.

The Clinical Senate consists of a group of representatives including health clinicians, social care professionals, patient and citizen representatives and representations from organisations involved in commissioning services. The role of the Clinical Senate is to provide independent, strategic clinical advice to health commissioners.

In 2015, The Clinical Senate were involved in carrying out review work relating to the Better Care Together proposals.

In January 2018, the Clinical Senate reviewed maternity services. The Senate were supportive of the proposal but highlighted that supporting evidence is required for a robust approach to justify the change. The Senate commended the detailed demographic information provided as part of the plan.

The proposals have support from clinical leadership with agreement that the proposals will ensure sustainable safety and quality of services whilst achieving greater equity of access to services the LLR area.

11.0 Patient experiences of health services:

Patient experience information has been collated from a number of sources. These include:

1. CQC inspection reports for G.Ps and NHS Trusts
2. Healthwatch reports
3. Family and Friends Test
4. Past Engagement work (pre consultation engagement work)

11.1 CQC reports:

Across LLR there are 40 G.P practices. Following CQC, 10% of GP practices have been inspected by CQC and require improvement. 3% were rated as inadequate.

Providers CQC ratings are:
University Hospitals of Leicester NHS Trust - overall requires improvement
Leicestershire Partnership Trust (mental health provider) – overall requires improvement
East Midlands Ambulance Service NHS Trust – overall requires improvement

Sources:
https://www.cqc.org.uk/search/site/university%20hospitals%20leicester%20nhs%20trust?location=&latitude=&longitude=&sort=default&la=&distance=15&mode=html
https://www.cqc.org.uk/provider/RT5

11.2 Healthwatch reports:

Healthwatch organisations working across the LLR are:
Healthwatch Leicester and Leicestershire

Healthwatch Rutland

Healthwatch is a national network spread over all local authorities in England. They provide an independent voice for gathering patient and public views about health and social care services. Reports on various aspects of healthcare are used to help shape services and help to inform decisions made by commissioners and providers. Healthwatch has a set of statutory activities to undertake, such as gathering local views and making these known to providers and commissioners, monitoring and scrutinising the quality of provision of local services.

This assessment has considered a range of Healthwatch reports conducted in the last 24 months across the LLR area which include:

- Healthwatch Rutland response to draft Sustainability and Transformation Plan
- Military Veterans
- Dementia
- Young people's mental health report

Summary of patient experiences from Healthwatch:

11.2.1 Response to LLR draft Sustainability and Transformation Plan:
Report was compiled in March 2017 as a response to the LLR STP plans by Healthwatch Rutland. In relation to the proposals relating to this assessment the following issues were raised. (1) concerns with transport and increased travel for people living in different parts of Rutland. This is cited as 56-66 mile round trip for some patients. (2) poor public transport links (3) concern over choice regarding Midwife Led Birthing Unit. The reports response to the proposed dispersal of services from LGH and proposed closure of the LGH with request for site plan of what will remain on the site. The report notes concern with the plans of Maternity services. This raises an issue of possible increase of home births and if potential capacity issues may lead to women being sent to Midwife Led Birthing Units at Peterborough rather than LGH.

11.2.2 Dementia report:
Report was compiled in May 2016 by Healthwatch Rutland. Report noted that although there are many good services for patients with dementia the report noted concern with delays in appointments and waiting times. Particular issue for Rutland due to aging population. Key concerns raised include confusing routes into getting support and diagnosis, confusion when getting treatment and information, the coordination of treatment and support providing in the community.

Concerns were raised with care in hospital. Concerns include difficult routes into hospital pathways with a variety of routes used to securing a bed via health or social care professional. Other concerns include delays in hospital discharge, inappropriate discharge and needing to attend different hospitals.

Report notes that all age prevalence rate of dementia in Rutland is above the national rate – which may reflect the age profile of the area. The report cites JNSA data that dementia in Rutland is expected to double between 2016 and 2030.

11.2.3 Young people's mental health report:
Report was compiled by Healthwatch Rutland in August 2016.
1000 young people took part – citing mental health as their biggest concern. This was linked to a number of areas such as pressures faced in school / college, bullying on social media, dealing with ill health (their own ill health or a close family member) and experiencing loneliness.

Young people told Healthwatch that the use of alcohol, drugs was sometimes considered as a coping mechanism, alongside self-harming and eating too little / too much.

Primary schools in the area report adverse impacts on children – especially dealing with family breakdown, bullying, self-confidence, loneliness, illness, bereavements, anxiety and body issues / eating issues. Schools further report that impacts are being seen in younger children and increasingly amongst boys.

A relative small number of young people turned to professional health care service however when they did, they considered this helpful. 5% of the responses said they had sought help from A&E with 66% of these citing it was helpful. 8% of respondents said they had sought help from a G.P with 76% of these finding this helpful.

The report notes the interlinked coordination of supporting young people through school staff, school nurses, Educational Psychologist and the CAMHS service.

11.2.4 Military Veterans report:
Report was compiled by Healthwatch Rutland in June 2017. The health care of serving and those who have served in the armed forces are covered by the Armed Forces Covenant – with extends to their families. This ensures that they should not face any disadvantage over their care compared to other citizens. The covenant enables special consideration to be applied – which may include bereaved or injuries.
The report was based around a workshop event supported by statutory bodies, military units and charities – including military charities.
During the event improvements were suggested to enable better partnership working between different organisations including voluntary and charity sector. Improvements could be made to supporting military veterans through promoting support within NHS locations such as G.P practices.

This work highlighted that veterans developing mental health problem benefit from early interventions. The report notes that although the majority of serving personnel do not have mental health problems, they can develop after discharge.

The work carried out in this workshop raised the issue that not everyone accessing information the same way. The report also raised that not all health services have a good awareness of the needs of veterans.

11.2.5 Enter and view visit at GP Assessment Unit and Acute Medical Unit at Leicester Royal Infirmary report:
Report is based on the visit which took place in July 2017. The report was compiled by Healthwatch Leicester. This visit gained first hand experiences of patients and their carers / relatives. The visit also provides an opportunity to observe the nature and quality of services.

Overall, patient experience of their care received from clinical staff was very positive. The visit took place within the new Emergency Department and the report noted that considerations include but are not exclusive to; (1) information to patients on other patient services, (2) permanent signage, (3) disability access assessment.

11.2.6 In Mum's Words – A look at Maternity Services report:
Report was compiled in July 2016 by Healthwatch Leicestershire. The report focused on antenatal experiences, birth experiences and neonatal experiences. Feedback from mums noted that the relationship with their midwife was really important and mums wanted care to be delivered by the same midwife throughout pregnant to birth. Mums also noted that they wanted to have their partners stay with them. The report was completed after the release of the National Maternity Review: Better Births – Five Year Forward View for NHS maternity services in England.

Sources: http://healthwatchrutland.co.uk
https://www.valonline.org.uk/sites/www.valonline.org.uk/files/hw-leicestershire-annual-review-2018_0.pdf
http://healthwatchll.com/

11.3 Family and Friends Test:
The Friends and Family Test is a nationally recognises set of questions to gain information on the experience of care people receive whilst in hospital. The main question centres if people would recommend the care they received to their family and friends if they needed similar care. The test is mandated by NHS England and reported regularly to them.

University Hospitals of Leicester NHS Trust publish their results of Friends and Family Test on their website - patient pages section.

In summary performance from reporting in May 2018:

	Inpatient Services	Maternity Services	Emergency Department	Outpatients services
Number of responses	5317	1371	1912	6461
Would recommend	98%	94%	96%	96%
Would not recommend	1%	2%	1%	2%
Don't know	1%	4%	3%	2%

Source: http://www.leicestershospitals.nhs.uk/patients/thinking-of-choosing-us/patient-experience/friends-and-family-test/

Analysis: The Family and Friends test performance table shows a high level of satisfaction for patients using services across UHL. Across the different services, maternity services has the lower recommendation rates.

12.0 Engagement work so far:

This section is supported by Healthwatch section 11.2

Initial engagement work commenced in the year 2000 as part of the Pathway Project. Further work as part of the STP started in 2014.

Engagement work on the plans took place throughout 2014. A Patient Participation Involvement group was set up and service user groups were developed within the work streams of the Better Care Together work. Close communication with stakeholders within the campaign work with regular updates being provided to local politicians and the Overview and Scrutiny Committees. Engagement work has been conducted by the Better Care Together programme, previous this, the STP and engagement with Clinical Senate.

The requirement of conducting formal public consultation is a subsequent process following the successful submission of the Pre Consultation Business Case to NHS England. The following engagement and insight work documents pre consultation engagement activities relating the Better Care Together proposals.

12.1 Engagement during March 2015:

The aim of the campaign was to:

- Raise awareness of Better Care Together Programme
- Seek views from the public on issues that were important to them with monitoring information gathered for those taking part
- Targeted communication campaign aimed at stakeholders, public and staff
- Included workshops and a mobile unit aimed at speaking to people within seldom heard groups
- Range of media promoted the campaign such as local radio, television and newspapers
- Social media promoted the campaign through Facebook, Twitter and website information
- Work promoted through Local Authority, UHL and CCG's websites and publications
- Engagement work included a range of ways to take part including easy read version, mobile outreach and online questionnaire

The above promotion of the campaign reached an estimated 800,000 people with newspapers. Additional media coverage estimates 400,000 people heard about the campaign. Online visits to the Better Care Together website went up from 2999 visits in February 2015 to 17.650 in March 2015. The Twitter account made 50584 impressions and had 340 followers during the month of March 2015.

Monitoring questions were included within the response, these included:

- Disability / long term conditions
- Sexual orientation
- Marriage and civil partnership
- Religion and belief

Who took part in giving feedback:

The campaign resulted in 1061 people responding.

Number of responses from different methods:

- Responses from easy read questionnaire: 101
- Responses from mobile outreach: 702
- Online responses: 258

Monitoring information taken from people responding to the engagement work indicated that:

- 35% responses were from 35-39 year olds
- Children and young people were unrepresented accounting for 6%
- Responses unrepresentative of the diverse ethnic backgrounds within Leicester City with 81% of responses being white British and 7% BME

Where did engagement take place:
Engagement work took place across the LLR area.

21 visits to seldom heard groups and using the mobile engagement unit enabled the engagement team to gain the views of seldom heard groups with the nine protected characteristics represented.

The areas visited by the mobile unit included:

1. Fosse Park Shopping Centre
2. Loughborough
3. Leicester City Centre x2
4. Thurmaston

5. Hinckley
6. Melton
7. Oakham
8. Coalville
9. Market Harborough
10. Lutterworth
11. Wigston

Work also included G.P Participation Groups (PPG'S)

Seldom heard groups:
Visits to gain the view of different group took part as part of this work. These groups included:

- Young mums group
- Gypsy traveller group
- Older men
- Disability groups including learning disability
- Carers
- Sikh community centre
- Mental health group
- Transgender support group
- Widows group
- Pregnancy group / new mums
- Age UK
- AIDS support groups

Summary of engagement feedback:

- There was broad support for an integrated health and social care system
- There was broad support for the Better Care Together plan
- Services need to change in order to meet the changing needs of the population – 89% agreed
- Hospitals should focus on specialist and emergency care – 87% agree
- Non specialist and non emergency care should be directed at community hospitals and G.P services – 87% agree
- Waiting times for non-urgent and simple procedures are most important factor followed by travel distance (when distance is minimum 30 min drive) 68% rated waiting times most important compared to 20% rating travel distance as most important
- Waiting times for major operations is important – 71% agree
- People want services closer to home

- Services need to be accessible by public transport

- Concerns raised within the engagement includes:
    - Reduction of hospital beds
    - How changes will be funded
    - extra travelling in the event of services moving to different locations – public transport links
    - car parking facilities
    - home first principle – feasibility of it working
    - being treating in the right place and getting a hospital bed if needed
    - supporting carers and families as part of the home first principle
    - for patients experience social isolation
    - support when discharged from hospital (role of integrated locality teams for caring for patients with long term conditions and frail patients)
    - impact on services due to closing the Midwife Led Birthing Unit at St Marys Hospital in Melton Mowbray

12.2 Engagement work – November 2016 to May 2017:

Engagement work followed the publication of the Better Care Together Plan at the end of November 2016. Engagement work sought public and stakeholder views on the plan.

Who took part in the engagement work:
A total of 11,929 people responded within the communication and engagement work between November 2016 and May 2017. Of these, 7,264 visits were made to the STP website page. There were 3345 reaches on Facebook. 650 people attended public meetings of which 10 were held.

Where did engagement take place:

Engagement took place at a range of venues and through different methods, including:

- Public events
- Visits to gain views from range of seldom heard groups
- Political engagement groups
- Equalities challenge group
- Digital and social media
- STP PPI group

- Email and letter responses

Summary of engagement feedback:

In general there was broad support for the plan.

Concerns with the plans include:

- Detail needed and evidence behind the choices
- If there is enough resources for delivering the home first principle
- Ability for health and social care to meet demands within the resources they are given
- Concern with the community based model – especially for rural communities
- Rutland area fairing less favourably with the plans
- 111 service and historical patient experiences
- Impact of moving services onto three sites to two
- Out of hours services delivered by G.Ps
- Community services being accessible by public transport
- Voluntary sector wanting greater input in the plans

12.3 Specific Engagement carried out by University Hospitals of Leicester NHS Trust

Acute services

The long term feasibility of managing the delivery acute services and estates over Leicester has been discussed locally, regionally and nationally for the past 20 years.

The timeline for engagement work includes:

Year	Work
2000	Full options appraisal as part of the Pathway project. Included public engagement work
2008	Next stage review
2013	Option appraisal work for acute reconfiguration – workshops and stakeholder involvement
2014	Better Care Together Strategic Outline Case – November

2015	Option appraisal work for maternity reconfiguration – workshops and stakeholder involvement
2015	Better Care Together – pre consultation engagement campaign
2015 updated 2016	Delivering Care at its Best 5 Year Plan
2016 and 2017	Strategic Transformation Plan – engagement in early 2017

The nature of the engagement work includes:

- UHL Members Engagement Forum group involved in the Trust Plans
- Annual Public Meeting – more than 100 members of the public

Maternity Services

Engagement work on reviewing maternity services started in 2010 in which identified that women said that the most important factor in their care was having safe services. This work also noted that 2 from 3 women would opt for a consultant led maternity unit rather than a Midwife Led Birthing Unit. It was also noted that women wanted antenatal and postnatal care closer to home.

Specific engagement work on the proposal work for maternity services started in Spring 2015. This included:

- Initial public listening event – 'Have Your Say' – hearing views on childbirth and gynaecology services
- Involvement of Healthwatch representatives and Patient Participation Involvement representatives in the option appraisal process
- Engagement events involving local parent groups - targeted to include groups with protected characteristics
- Better Care Together engagement campaign with specific maternity questions

Engagement has taken place with a range of stakeholders, patient groups and clinicians. These included:

- Better Care Together Maternity and Children's Steering Group
- Women's Project Board
- Parent and toddler groups
- Breastfeeding support groups
- Healthwatch across the LLR area
- Sharma Women's Centre (Asian women's group)
- County Councillors and Borough Councillors

UHL have informed this assessment that feedback from some individuals have raised a concern over the future of some of the estate buildings for heritage and cultural protection. As a result of this, the Better Care Programme have a representative from a Heritage Officer from Leicester City Council.

13.0 Future engagement planned:

Formal consultation for the proposals is planned for spring 2019. This will aim to further discuss the proposals, gain a better understanding of differing views about the proposals and promote greater awareness of the Better Care Together plans.

The consultation plan aims to enable ‘ease of access’ for people to provide their views. This work aims to demonstrate representative engagement across the LLR population.

The consultation plan is currently being developed and it is envisaged that this assessment will further inform the formal consultation plan. Consultation activities planned include:

- 12 week consultation period in line with national good practice
- Consultation document available in differing formats and versions
- Short versions of the consultation documents
- Online survey and printed version available
- Supporting presentation and materials available
- Supporting publicity to promote engagement and promote across different media
- Distribution points to ensure wide distribution
- Social networking to ensure wide distribution
- Public workshops, meetings and events
- Collaboration with Healthwatch and voluntary organisations to reach a wide demographic reach
- Consultation meetings to involve stakeholders and staff
- Coordinated management of feedback
- Responses to the consultation to be independently reviewed

14.0 Impact section

14.1 Acute services: Impact tables for each group

Using the above sections the following table documents the potential impacts for the proposed changes on different groups of people.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Age	x		

Explanation:

Acute services usage is higher for young and older people with chronic conditions. An aging population is placing greater demands on the system.

The proposal for acute services should be positive on all due to addressing better quality of care, safety of staffing services and system changes which address waiting lists.

Changes are related with the Frailty Programme should improve care for older people and Leicester Health and Social Care Integration Programme

Changes with principle of Home First and community care should reduce need of unnecessary journeys into hospital.

Some age groups are more likely to use public transport – younger people and older people. Travel analysis has found no adverse increase of travel times for public transport from moving services from LGH to LRI or GH.

Children and Young peoples care should be positively impacted by care being delivered on one site. This enables specialist staff to deliver their care and emergency care is also on site.

Previous engagement work involved a range of stakeholders and people from different age groups.

Related recommendations:

Formal consultation work to include all age groups – pre engagement work had low representation from younger groups.

Formal consultation to link in with groups representing the interests of age groups such as:

- Older peoples' forums
- Younger peoples' forums

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Disability	x	X travel for some postcodes	

Explanation:

Acute services usage is higher for young and older people with chronic conditions. Usage increases with the number of chronic conditions.

The management of chronic treatments within the proposals and wider system changes should be a positive change for these patients.

The location of children's services on one site should benefit children with long term disabilities which require hospital care.

The proposals note that improvements to parking facilities will be made on the LRI site.

Travel Analysis work shows that some postcodes will be negatively impacted by increased travel distance. This may impact on disability groups specifically as they may not have access to a car, have mobility difficulties and possible increased costs. Cross reference this section with Vulnerable groups for issue on travel time and costs.

Previous engagement work has involved disability groups. They did not highlight any impacts from this group differing from concerns from the general population.

Related recommendations:

Current information on the estates notes that improvements should be made to signage and welcome areas. This assessment recommends that disability groups are involved in work to assess accessibility of any new or development work to the estates. This may include audits, walk-throughs and involvement of people with disabilities for a real-life understanding of the hospital environment.

Further plans for formal consultation notes that any materials should be in different formats, this assessment recommends that as standard good practice, an easy read version of the consultation document and questionnaire is made available.

This assessment recommends that all materials should be available to meet the requirements of the NHS Accessible Information Standard.

Proposals for improving parking facilities on the LRI site should include further detail on disabled parking facilities

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Gender Reassignment			x

Explanation:

Care for people undergoing gender reassignment falls under Interim gender dysphoria protocols 2013/14.

The proposals do not directly impact people undergoing any core gender reassignment treatments, however this assessment acknowledges that this group are often disadvantaged within healthcare due to a general lack of understanding of transgender issues. Lack of understanding may relate to staff and other patient groups.

Previous engagement work involved LGBT groups. Previous engagement work has not highlighted any impacts from this group differing from that of the general population.

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population. As this is a seldom heard group and views are generally under represented, consultation work should specifically target local LGBT groups to ensure any understanding on the needs of this group are included within further decision making.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Marriage and Civil Partnership			x

Explanation:

Marriage and Civil Partnership protection applies for employment and not within service provision. This assessment has gathered evidence of UHL staffing profiles but acknowledges that national rates for Civil Partnership is not current data and based on the 2010 census.

Links with workforce section notes that there is no planned job losses however that job roles may change and become more flexible to meet the changing nature of the system changes. Cross reference this section to impact table on workforce.

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population. Staff should be included with the formal consultation and monitoring information included to identify responses from staff.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Race			x

Explanation:

Previous engagement work involved different ethnic groups however monitoring data highlights that responses from Leicester City was not representative of its diverse population. Previous engagement work has not highlighted any impacts from this group differing from that of the general population however this representation was low.

Although this current assessment has not identified any negative impacts from the proposals, there is not sufficient information from the pre engagement work to give full assurance to this. Formal consultation work will provide further understanding of the needs of this group.

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population. As this is a seldom heard group and views are generally under represented, consultation work should specifically target local minority ethnic groups to ensure any understanding on the needs of this group are included within further decision making.

This assessment recommends that consultation materials are available in differing languages and when speaking to minority ethnic groups that interpreters are available. Consideration of women only sessions to meet the cultural needs of specific groups which are generally under presented. This may be particularly pertinent for acute services relating to women's care.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Religion and Belief			x

Explanation:

Previous engagement work has not highlighted any impacts from this group differing from that of the general population.

There is no plan to reduce meeting spiritual and religious needs for patients in their care. Current information on hospital services highlights that the chaplaincy services within HLC includes Christian, Hindu, Muslim and Sikh Chaplains as well as a non-religious Pastoral Carer. The wider team of volunteers also includes Baha'i, Buddhist, Jewish and Jain representatives.

Chaplaincy rooms are available for both staff and patients.

Linked to cultural and religious needs, the proposals aims to address the dignity of patients. This may be include separate changing areas for men and women (cross reference to table on sex) and having a designated space for worship / prayer.

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population.

This assessment recommends that any changes in the estates ensures that there is provision on each site for chaplaincy services and a dedicated room for patients and staff.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Sex			x

Explanation:

Previous engagement work has not highlighted any impacts differing between men and women.

The proposals aim to address dignity of patients and the quality of their care and therefore this should be a general positive for everyone.

Accommodation within the two sites should improve facilities and meet standards of changing facilities and wards.

Accommodation and facilitates should be meeting standards to provide sex related facilities. Although people from all backgrounds would welcome this, this will meet the cultural needs of some men and women from certain religions where it is culturally not acceptable to dress in mixed sex situations.

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from men and women differ. This assessment recommends that any changes in the estates ensures that there is provision within day cases / acute service for changing areas to maintain dignity within single sex facilities.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Sexual Orientation			x

Explanation:

Previous engagement work has not highlighted any impacts from this group differing from that of the general population.

Information on the experiences of Lesbian, Gay and Bisexual groups highlight that they often face barriers within health care. This group commonly have poor experiences of primary and secondary care. This may relate to a lack of understanding and societal prejudice. Understanding of the needs of this group can be improved with good staff training and links with the LGBT community.

The work of UHL with LGBT groups is not fully explored yet but should form part of ongoing work in line with meeting the three aims of the public sector equality duty.

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population. This would be helpful as there is limited information from previous engagement work.

This assessment identifies a current gap in information regarding the involvement of LGBT groups within the work of UHL

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Pregnancy and Maternity	x		

Explanation:

Protection regarding this characteristic is usually applied to employment however does include service provision.

Previous engagement work has not highlighted any negative impacts from this group differing from that of the general population for the configuration of acute services.

Consultant led care during pregnancy on the LRI site should be enhanced due to specialist staff being located on one site. The co-location of dedicated children's services on one site including that of neonatal care was highlighted as a positive aspect of future care within the engagement work.

This section of the assessment only relates to acute proposals. Maternity proposals will be considered separately.

This assessment to acquire further information on accommodation for neonatal care to check if parents can stay overnight with their baby receiving special care.
Related recommendations: This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Staff	x		
Explanation: Rationale work for the proposal highlights a number of current problems such as staffing problems (including unsafe staffing problems) , low staff morale and frequent travel from one site to another. The proposals should address the current workforce problems. The proposals notes that staff roles may change in order to meet the changing system changes. There will not be any loss of jobs. The proposals notes that car parking facilities at LRI will be improved. This assessment does not currently have information on the potential increase of car parking demands from staff that are locating onto the site. This issue will also apply on the GH site. This assessment acknowledges that some staff may have increased travel time due to the relocation of acute services from LGH to GH or LRI. This issue should be included within formal consultation work. This assessment acknowledges that some volunteers working at UHL may have increased travel time due to proposed changes. This issue should be included within formal consultation work.			
Related recommendations: This assessment recommends that consultation responses are disaggregated to include staff to evaluate if views / impacts from this group differ from the general population.			

This assessment recommends that information is provided for staff on potential job changes to ensure that staff are involved and not worried about changes that may affect their conditions of work. This may involve carrying out further assessment work in order to identify potential impacts on staff such as those who provide care, have children or have other commitments. Further assessment work would be helpful in order to assess car parking demand across the sites and travel following relocation of services.

This work should also consider impacts on volunteers.

Although initial travel analysis does not indicate additional time for the Ambulance Service, these staff should be included within consultation work as they may highlight any impacts not already identified.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Other vulnerable groups		X travel costs	

Explanation:

Deprivation: The main areas of deprivation are found in Leicester City although there are pockets of deprivation across the LLR area. The main impact for people living in poverty or low incomes is possible additional travel costs when using public transport. This will mainly impact on low income people that access services at LGH and for those whose travel is increased for the changes between LRI and GH. The travel analysis for acute proposals does not currently contain additional cost information in order to understand this potential impact further.

Carers: Carers living in areas where they may have further to travel and possible increased travel costs may be impacted. Young carers and older carers may not have access to public transport.

Rural areas: The travel analysis information shows that some postcodes in rural areas to the east of the footprint will be impacted by the increase travel for acute services from LGH to GH or LRI. This engagement work found that people rated waiting time above travel time. Increased travel time may be experienced for patients using car, taxi and public transport. There may be higher costs linked to increased travel distance / time. There is currently limited information on this aspect of travel impact.

Asylum Seekers and Refugees: The needs of this group are complex. They often face barriers in accessing primary and secondary health care.

Related recommendations:

This assessment recommends that consultation responses are disaggregated for postcode (first part) to evaluate if views / impacts from different areas differ from the general population.

This assessment recommends that further work on the travel analysis is carried out on costs and times for patients using public transport. This will provide further understanding of the impact of further travel. This include cost, frequency of buses to the GH/LRI.

This impact for carers should be explored and further understood as part of the public engagement work. The consultation monitoring questions should include 'carer' as a monitoring question to gain greater understanding of how and the extend of impact.

This assessment recommends that formal consultation work includes organisations that support people seeking asylum and involve this group in order to fully understand if the proposals impact on them. Cross reference with race – on issue of language and interpreters.

14.2 Maternity services: Impact tables for each group

Using the above sections the following table documents the potential impacts for the proposed changes on different groups of people.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Age	X consultant led births	X Melton Mowbray mums	

Explanation:

The proposals of the Better Care Together programme involves the closure of the Midwife Led Birth Unit at St Marys. The unit is not financially viable to the low numbers of births.

Melton Mowbray mums: Previous engagement work has involved pregnant women and new mums. Women planning a baby / pregnant (child bearing age) living in or near to Melton Mowbray may be impacted by the closure of the unit as they will have further to travel. This impact will be experienced for those who choose a midwife led birth. This will potentially impact 172 women per year. Mitigation information within the Better Care Together plan notes that some women could opt for a home birth (similar to the ethos of midwife led unit). Opting for a home birth may not be a viable solution for some women due to a number of factors. Travel analysis work has been carried out on travel distance, time and costs including public transport. Some identified postcodes may choose to use services outside of LLR to have their baby.

Standalone Midwife Birthing Unit at LGH: the proposal for a unit at LGH (piloting for a year) will test the sustainability of the unit. This option was identified as less impact for travel analysis work compared to the option of not having a standalone unit. During the appraisal

option process, a number of locations were considered. The Leicester location was preferred due to the accessibility and distance across the LLR footprint. For 2015/16 the projected number of births at LGH is 4636.

Consultation led care: The proposals of a new maternity hospital at LRI adjacent to obstetrics and neonatal care has received positive feedback within the engagement work. Feedback and data on the use of the Midwife Led Birthing Unit indicates that women prefer being on a site with supporting services. For 2015/16 the projected number of births at LRI is 6005.

The proposals include a short stay drop off area for women giving birth.

Related recommendations:

Proposals for improving parking facilities on the LRI site should explore accommodating the needs of women in labour and be located near to maternity unit.

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population.

This assessment recommends that consultation responses are disaggregated for postcode (first part) to evaluate if views / impacts from different areas differ from the general population.

Consultation work to closely link with Maternity Voice Partnership who will be able to link with vulnerable mums such as young parents, those with long term health conditions, substance misuse and domestic abuse.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Disability			x

Explanation:

The proposals of the Better Care Together programme involves the closure of the Midwife Led Birthing Unit at St Marys. The unit is not financially viable to the low numbers of births.

Melton Mowbray mums: Women with disabilities planning a baby / pregnant (child bearing age) living in or near to Melton Mowbray may be potentially impacted by the close of the unit as they will have further to travel. There is no current data of the number of women using

the unit that have a disability. It is likely that these women would be cared for under specialist midwife and therefore would prefer to use the services at LGH or LRI. The proposals include a short stay drop off area for women giving birth.
Related recommendations: Proposals for improving parking facilities on the LRI site should explore accommodating the needs of women in labour and be located near to maternity unit. This assessment recommends that consultation responses are disaggregated for disability to evaluate if views / impacts from different areas differ from the general population. The consultation work should also involve disability groups within the estate redevelopment work to ensure the environment is meeting the needs of people with disability. This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population. This assessment recommends that consultation materials are available in easy read and different formats to comply with the NHS Accessible Information Standard. Consultation work to closely link with Maternity Voice Partnership.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Gender Reassignment			x
Explanation: No current impacts have been identified from engagement work.			

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from different protected groups differ from the general population. The consultation work should also involve LGBT groups as they are generally underrepresented within consultation work.

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Marriage and Civil Partnership			x

Explanation:

Marriage and Civil Partnership protection applies for employment and not within service provision. This assessment has gathered evidence of UHL staffing profiles but acknowledges that national rates for Civil Partnership is not current data and based on the 2010 census.

Links with workforce section notes that there is no planned job losses Cross reference this section to impact table on workforce.

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population. Staff should be included with the formal consultation and monitoring information included to identify responses from staff.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Race			x

Explanation:

Previous engagement work involved different ethnic groups however monitoring data highlights that responses from Leicester City was not representative of its diverse population. Previous engagement work has not highlighted any impacts from this group differing from that of the general population however this representation was low.

Although this current assessment has not identified any negative impacts from the proposals, there is not sufficient information from the pre engagement work to give full assurance to this. Formal consultation work will provide further understanding of the needs of this group.

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population. As this is a seldom heard group and views are generally under represented, consultation work should specifically target local minority groups to ensure any understanding on the needs of this group are included within further decision making. This includes speaking to the Gypsy and Traveller community to seek their views of the proposal.

This assessment recommends that consultation materials are available in differing languages and when speaking to minority ethnic groups that interpreters are available. Consideration of women only sessions to meet the cultural needs of specific groups which are generally under presented. This may be particularly pertinent for gaining views on maternity services.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Religion and Belief			x

Explanation:

Previous engagement work has not highlighted any impacts from this group differing from that of the general population.

Linked to cultural and religious needs, the proposals aims to address the dignity of patients. The proposals do not impact on women choosing to have a home birth.

Further consultation work may provide greater understanding on the impacts of these proposals for groups holding differing beliefs.

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population.

This assessment recommends that any changes in the estates ensures that there is provision on each site for chaplaincy services and a dedicated room for patients and staff.

Consultation work to closely link with Maternity Voice Partnership

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Sex	X Consultant led care	X Melton Mowbray	

Explanation:

The proposals for maternity services directly affect women that are having or planning a baby.

Previous engagement work has highlighted that women prefer care where there are supporting services available. The proposal to build a new maternity hospital at LRI has received positive feedback as maternity unit will be co-located with obstetrics and neonatal care on the same site. There were some concern relating to parking. The proposal included plans for a short stay drop off area.

The closure of the St Marys due to low number of births will impact negatively on women in this area that would have used this unit. Data suggests that this affects around 172 mums.

The proposal to retain a standalone Midwife Led Birthing Unit at LGH enables mums in across the LLR area to have the option of a Midwife Led Birthing Unit without the clinical surrounds of a large hospital delivering emergency care. The viability of this unit will be tested with monitoring number of births and staffing. Appraisal option work noted that the location of LGH was favourable in terms of access across the LLR.

The low numbers of births at St Marys was in part to the geographical location. For 2015/16 the projected number of births at LGH is 4636. For 2015/16 the projected number of births at LRI is 6005.

The Healthwatch report In Mum's Words – A look at Maternity Services report noted that women wanted continuity of care from their midwife. This is also noted with the Better Births review. The proposals aims to improve the care of women during pregnancy.

There should be a positive impact for mums and their babies requiring additional care after their birth with services being located on the LRI site.

This assessment acknowledges that antenatal and postnatal care and home birth service will not be affected by the proposal.

This assessment to acquire further information on accommodation for neonatal care to check if parents can stay overnight with their baby receiving special care.

Partners of pregnant women may be impacted by the proposals. There is limited information on potential impacts for partners / carers of pregnant mums. This may be more relevant for cases where a pregnancy is problematic and hospital stays are required.

Cross reference this section with Age table above.

Consultation work to closely link with Maternity Voice Partnership to include views of partner / carers / dads

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from men and women differ.

This assessment recommends that consultation work targets a range of women from different backgrounds (race, sexual orientation, young mums, older mums) to gain a wide understanding of the views of people with protected characteristics.

Issues of parking at LRI and impacts to partners / carers to be further explored in consultation work.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Sexual Orientation			x

Explanation:

Previous engagement work has not highlighted any impacts from this group differing from that of the general population.

Information on the experiences of Lesbian, Gay and Bisexual groups highlight that they often face barriers within health care. This group commonly have poor experiences of primary and secondary care. This may relate to a lack of understanding and societal prejudice. Understanding of the needs of this group can be improved with good staff training and links with the LGBT community.

The work of UHL with LGBT groups is not fully explored yet but should form part of ongoing work in line with meeting the three aims of the public sector equality duty.

Related recommendations:

This assessment recommends that consultation responses are disaggregated to evaluate if views / impacts from this group differ from the general population. This would be helpful as there is limited information from previous engagement work. Consultation work to closely link with Maternity Voice Partnership.

This assessment identifies a current gap in information regarding the involvement of LGBT groups within the work of UHL

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Pregnancy and Maternity	x		

Explanation:

Protection regarding this characteristic is usually applied to employment however does include service provision.

See above sections for impacts on pregnant women with protected characteristics.

This notes that consultant led care during pregnancy on the LRI site should be enhanced due to specialist staff being located on one site. The co-location of dedicated children's services on one site including that of neonatal care was highlighted as a positive aspect of future care within the engagement work.

The close of St Marys Midwife Led Birthing Unit will negatively impact around 176 women a year.

Related recommendations:

See other impact tables for recommendations

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Staff	x		
Explanation: Rationale work for the proposal highlights a number of current problems such as staffing problems (including unsafe staffing problems) , low staff morale and frequent travel from one site to another. The proposals should address the current workforce problems. There will not be any loss of jobs. The proposals notes that car parking facilities at LRI will be improved. This assessment does not currently have information on the potential increase of car parking demands from staff that are locating onto the site. This issue will also apply on the GH site. This assessment acknowledges that some staff may have increased travel time for staff that were based at St Marys. This issue should be included within formal consultation work. The proposal plans do not currently details how the proposed standalone Midwife Led Birthing Unit at LGH and the LRI services will be staffed. Further work or information is needed in order to understand the current problems between working between different sites.			
Related recommendations: This assessment recommends that consultation responses are disaggregated to include staff to evaluate if views / impacts from this group differ from the general population. Further assessment work would be helpful in order to assess car parking demand across the sites and travel.			

Equality Group / Protected Group	Positive effect	Negative effect	Neutral /Indirect effect
Other vulnerable groups	X Overall	X Melton Mowbray	

Explanation:

Deprivation: The main areas of deprivation are found in Leicester City although there are pockets of deprivation across the LLR area. The main impact for people living in poverty or low incomes is possible additional travel costs for those that would have accessed St Marys.

Carers: Carers living in certain areas may be impacted negatively by additional travel distance and associated costs. The impact of these proposals are not fully understood for this group but could be addressed within the public consultation work.

Asylum Seekers and Refugees: The needs of this group are complex. They often face barriers in accessing primary and secondary health care.

Overall the plans for a new maternity hospital on the LRI site co-located with neonatal services and obstetrics has received positive feedback within the engagement work.

Within the engagement process, voluntary groups have voiced that they want to be involved in the decisions within the Better Care Together plans.

Within the mitigation of impacts on women that would access St Marys, the option to give birth at home was noted. This may not be a viable option for women due to a number of factors. Home births are currently an option within the birthing plan but careful consideration should be given to it being used as a mitigation of impact following the closure of St Marys.

Related recommendations:

This assessment recommends that consultation responses are disaggregated for across protected characteristics to evaluate if views / impacts from groups differ from the general population. This should include carers.

This assessment recommends that formal consultation work includes organisations that support people seeking asylum and involve this group in order to fully understand if the proposals impact on them. Cross reference with race – on issue of language and interpreters.

This assessment recommends that voluntary sector are involved as stakeholders within the formal consultation.

15.0 Next steps / recommendations

The impact tables above have been completed to cross reference impacts on protected groups and other vulnerable groups for the proposals of both (1) acute services and (2) maternity services. These tables also contain recommendations from this assessment.

The recommendations mainly centre on next steps for the formal consultation work. Future consultation work is required to meet the requirements of equality legislation. Following formal consultation, a post consultation EIA should be undertaken. This should include additional information on potential impacts that have been identified within consultation work.

The people and Communities Board published (June 2016) six principles for developing good approaches to engage with people and communities. These principles were developed with a view of supporting the NHS Five Year Forward View. These principles are noted below with practical ideas of how this can be achieved within a consultation strategy.

Principles	Practical ideas for implementing within engagement strategy:
1. Care and support is person-centred: Personalised, coordinated, and empowering	All parts of the community are given the opportunity to give their feedback. In order to do this, different methods of engagement may be required (survey, telephone, focus groups) with differing formats available to meet individual communication needs – in relation to the Accessible Information Standard such as large print, audio, easy read documents. Some people may request support in interpretation of documents into differing languages.
2. Services are created in partnership with citizens and communities	Consideration of time for communities to become aware of consultation work and take part in any consultation work.
3. Focus is on equality and narrowing inequality	An equality monitoring form should form an intrinsic part of the survey. This will enable effective analysis (of responses) in relation to assessing if participation is reflecting broad representation of the area and to support identification of any trends. Monitoring should include all the protected characteristics together with additional consideration of Carer status and other vulnerable groups such as Asylum Seekers / refuges, War Veterans, economically active / inactive. Where decisions are particularly in relation to a geographic area, consideration should be given to collating first part on the postcode in order to disaggregate in to areas. Postcode or ward level information / information relating to economic activity will help identify deprivation and issues relating to health inequality. Participants should have the option not to share their demographic information.
4. Carers are identified, supported and involved	Carers should be included within the consultation and monitoring should be included for Carer status.

5. Voluntary community and social enterprise, and housing sectors are involved as key partners and enablers	Working with existing community networks - such as Healthwatch and the voluntary and community sector - to ensure that people at all levels are being involved in shared decision making
6. Volunteering and social action are key enablers	Involvement of stakeholders and voluntary sector within consultation and wide dissemination of decisions made following proposal stage. Build permanent and continuous relationships Consideration of voluntary groups in engagement with particular groups that are traditionally reluctant to engage with consultation work such as traveller community, BME groups.

Other considerations:

There is no legal guidance on how many people should participate however the Consultation Institute recommends that 1% of the population would be a good response rate.

Careful consideration of the questions used within the consultation work is needed in order to 'not lead' participates and elicit meaningful feedback on proposals and services.

During the consultation process, rationale for the proposal should be provided to help people understand why changes are being proposed. If saving money is one of the reasons for proposed changes to services, it is advisable to be open and transparent about this.

Midway analysis of consultation responses would provide a gauge to who was responding to the consultation and invest more time for targeted work where representation is low.

Although there may be general support of the plans, the information provided to the public should be clear about the long term plans for LGH and St Marys sites – such as possible housing development.

16.0 Conclusion:

This equality impact assessment has been based on existing information from a range of sources. This is a pre consultation equality impact assessment. The main findings are:

- We have not found the differential impact that would lead to unlawful discrimination linked to the proposals. However this may change following further work planned within the formal consultation work

- Where the assessment and impact section has highlighted potential for differential impact, the recommendation sections provide proposed actions to reduce risk
- The proposals set out reconfiguration of acute services and maternity services to address the needs of the whole LLR population, including those who currently experience disadvantage. The plans are intended to help improve quality of care, access, experience and outcomes for all.
- The proposals for acute services could have significant positive impacts for those that experience health inequalities for adults, children and young people by improving the quality of care and access to more services in the community.
- This is also inter linked with wider system changes. This will support people with chronic conditions and complex needs. This should lead to an improvement in the management of conditions, prevent more extreme intervention being needed and reduce waiting times for urgent care, emergency and acute services.
- The proposals will have some negative impacts on people having to travel further to access services – depending on where they live
- The next steps are to carry out a formal public consultation to further assess and identify any impacts from the proposals

17.0 Abbreviations

BME: Black Minority Ethnic
CQC – Care Quality Commission
GH - Glenfield Hospital
ICU: Intensive Care Unit
JSNA: Joint Strategic Needs Assessment
LLR – Leicester, Leicestershire and Rutland
ONS: Office of National Statistics
PCBC: Pre Consultation Business Case
PPG: Patient Participation Groups
SMBC – St Marys Birthing Centre
SWOT: Strengths, Weaknesses, Opportunities and Threats
STP – Sustainable Transformation Plan
TIA – Travel Impact Analysis
UHL: University Hospitals of Leicester NHS Trust

18.0 Resources / documents used to support this assessment:

The Health and Social Care needs of Lesbian, Gay and Bisexual people in Leicester Report to the Leicester Public Health Partnership, September 2006 (updated May 2007) source: https://www.leicester.gov.uk/media/179049/the-health-and-social-care-needs-of-lesbian-gay-and-bisexual-in-leicester.pdf

Census data source: https://www.nomisweb.co.uk/reports/localarea?compare=1119885107

Public health data sets: sources:

https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy/data#page/0/gid/1938132993/pat/120/par/E54000015/ati/152/are/E38000051

JSNA data sets: sources:

http://www.lsr-online.org/uploads/background-and-demography-report.pdf

http://www.lsr-online.org/leicestershire-2015-jsna.html

http://www.lsr-online.org/uploads/dph-annual-report-2017.pdf

Better Births Improving outcomes of maternity services in England, National Maternity Review. 2016. Source:

https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Better Care Together - STP plan. Source: http://www.bettercareleicester.nhs.uk/EasysiteWeb/getresource.axd?AssetID=46236

Services University Hospitals of Leicester NHS Trust:

Chaplaincy: http://www.leicestershospitals.nhs.uk/patients/patient-and-visitor-services/faith-and-chaplaincy/

Reconfiguration of Acute and Maternity services at University Hospitals of Leicester NHS Trust
Pre-Consultation Business Case: DRAFT July 2018

http://www.leicestershospitals.nhs.uk/patients/thinking-of-choosing-us/patient-experience/friends-and-family-test/

http://www.leicestermaternity.nhs.uk/betterbirths/

MLCSU Commissioning guidance for Asylum Seekers and Refugees. Source:

https://www.midlandsandlancashirecsu.nhs.uk/download/publications/equality_and_inclusion/Asylum-Guidance.pdf

Leicester Health and Social Care Integration Programme. Source:
http://www.healthandcareleicestershire.co.uk/health-and-care-integration/

Leicestershire, Leicester and Rutland Gypsy and Traveller Needs Assessment Refresh: source:

www.blaby.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=14441

19.0 Appendices:

Appendix A: Information on Protected Characteristics

Appendix B: Maps showing proposed sites

Appendix C: Information tables of location of acute services

Appendix D: Travel analysis information for proposal of closing St Marys Midwife Led Birthing Unit

Appendix E: Table showing postcodes materially impacted by increased travel times – acute services

Appendix A: Information on Protected Characteristics

Age:

This refers to a person belonging to a particular age (e.g. 50-year-old) or range of ages (e.g. 18 to 30 year old). Age includes treating someone less favourably for reasons relating to their age (whether young or old).

Disability:

A person has a disability if s/he has a physical, mental impairment, Learning Disability or sensory impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. Disability includes sensory impairments such as sight and hearing. Also includes mental impairments such as Asperger's syndrome, autism, dyslexia and mental illness. Within the act there is no requirement that the mental illness has to be clinically recognised. The focus of the act is the impairment rather than the cause.

Certain medical conditions are protected under disability. These include Cancer, HIV and Multiple Sclerosis.

People with genetic conditions, would be protected under disability if the effect of the condition has a substantial and long term adverse effect.

People with a past disability which falls into the definition remain protected.

Gender Reassignment:

This refers to a person proposing to undergo, is undergoing (or part of process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex. The term of transgender falls under this protected group.

Marriage and Civil Partnership:

Protection is for people that are legally married or in a legal civil partnership. It only recognises people in formally recognised unions and therefore does not include people that are not married, cohabiting couples, widows, divorcees and fiancées. Protection of this group does not extend to service provision.

Race:

Race includes colour, nationality, and or ethnic or national origins. Nationality is determined by citizenship.

Religion and belief: The Equality Act does not define religion or belief explicitly. It includes the main world religions such as Christianity, Islam, Judaism, Hinduism, Sikhism, Humanism, Secularism and Paganism. The act protects any religion, religious or philosophical belief and a lack of religion / belief.

Sex:

A man or a woman, but also includes men and women as groups. Treating a man or woman or men and women less favourably for reasons relating to their sex. People describing themselves as non-binary are not currently recognised within the act.

Sexual Orientation:

A person's sexual attraction towards their own sex, the opposite sex or more than one sex. This includes people who are Lesbian, Gay, Bisexual or Heterosexual.

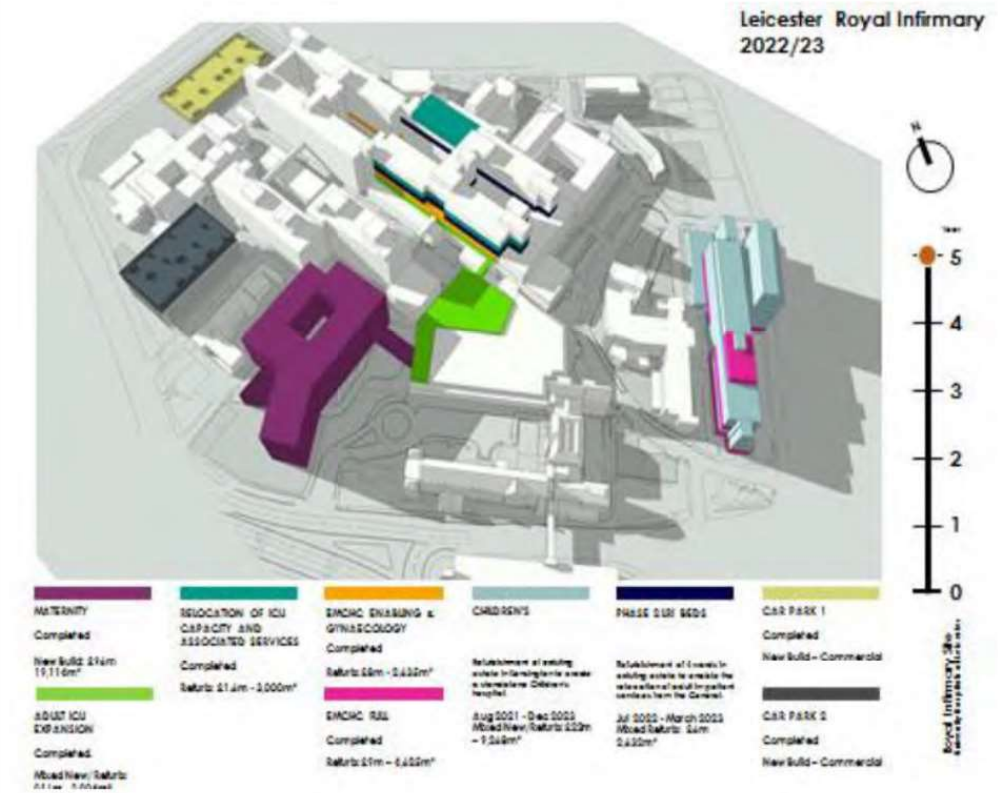
Pregnancy and Maternity:

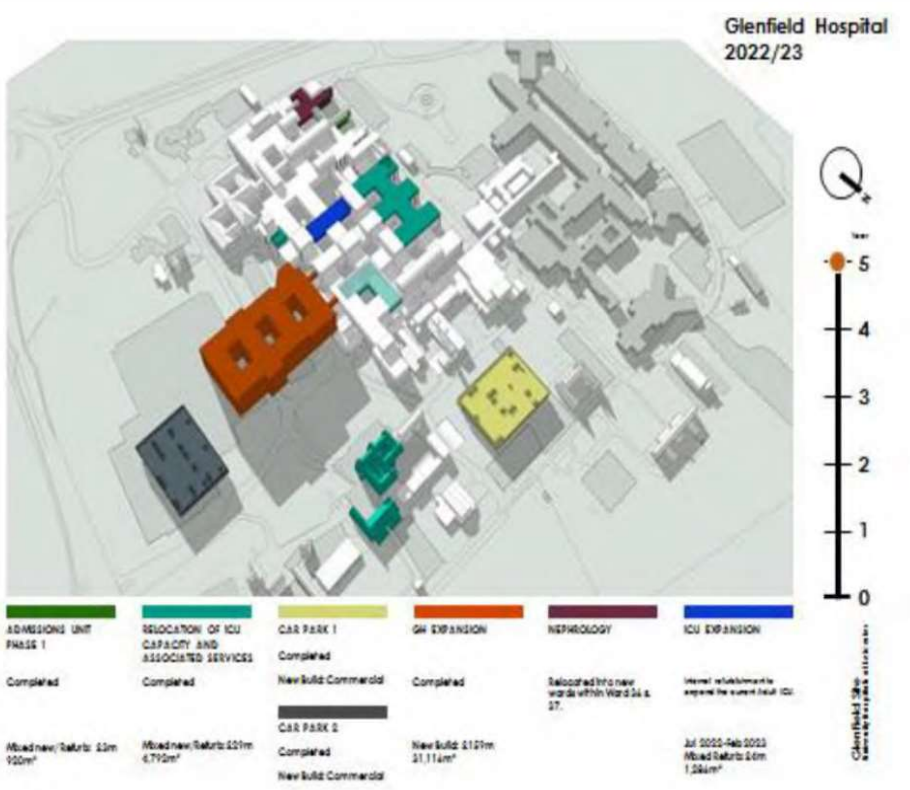
The act protects women that are discriminated due to their pregnancy or maternity – which includes breastfeeding. This protection may relate to current or previous pregnancy. Protection extends after the birth after 26 weeks from the date of the birth.

Protection includes women where baby was still born in cases where she was pregnant for at least 24 weeks prior to birth.

Appendix B: Maps showing proposed sites:

Leicester Royal Infirmary and Glenfield Hospital site:





Map of Leicester General Hospital

Appendix C: Tables of Proposed location for Services

Day case speciality	Current location	Future location
Chemical Pathology	LGH	GH – Treatment Centre
Clinical Immunology	LGH	GH – Treatment Centre
Dermatology	LGH	GH – Treatment Centre
Day case speciality	**Current location**	**Future location**
Ear Nose and Throat (ENT)	LRI	GH – Treatment Centre
ESRF	LGH	GH – Treatment Centre
Gastroenterology	LGH & LRI	GH – Treatment Centre
General Surgery	LGH & LRI	GH – Treatment Centre
Gynaecology	LGH & LRI	LRI
Gynaecology Oncology	LGH	LRI
Haematology	LGH	LRI
Hepatobiliary & Pancreatic Surgery	LGH & LRI	GH – Treatment Centre
Infectious Diseases	LGH	LRI
Integrated Medicine	LGH	GH – Treatment Centre
Interventional Radiology	LGH	LRI & GH

Nephrology	LGH	GH – Treatment Centre
Neurology	LGH	GH – Treatment Centre
Obstetrics	LGH	LRI
Orthopaedic Surgery	LGH	GH – Treatment Centre
Paediatric ENT	LGH	N/A
Pain Management	LGH	GH – Treatment Centre
Renal Access Surgery	LGH	GH – Treatment Centre
Rheumatology	LGH	GH – Treatment Centre
Sleep	LGH	GH – Treatment Centre
Spinal Surgery	LGH	GH – Treatment Centre
Sports Medicine	LGH	GH – Treatment Centre
Stroke Medicine	LGH	GH – Treatment Centre
Transplant	LGH	GH – Treatment Centre
Trauma	LRI	GH
Day case speciality	**Current location**	**Future location**
Urology	LGH	GH – Treatment Centre

In- patient speciality	Current location	Future location
Colorectal Surgery	LGH	LRI
Critical Care Medicine	LGH	LRI & GH
ESRF	LGH	GH
Gastroenterology	LGH	LRI
Emergency General Surgery	LGH	LRI
Gynaecology	LGH	LRI
Gynaecology Oncology	LGH	LRI
Hepatobiliary & Pancreatic Surgery	LGH & LRI	GH
Neonatal Intensive Care	LGH	LRI
Neonatology	LGH	LRI
Nephrology	LGH	GH
Neurology	LGH	LRI
Obstetrics	LGH	LRI
Ophthalmology	LRI	GH
Orthopaedic Surgery	LGH	GH
Renal Access Surgery	LGH	GH

Rheumatology	LGH	LRI
Sleep	LGH	GH /PCA
Spinal Surgery	LGH	GH
Sports Medicine	LGH	GH
In- patient speciality	**Current location**	**Future location**
Stroke Medicine	LGH	Evington Centre
Transplant	LGH	GH
Trauma	LRI	LRI
Urology	LGH	GH
Well Baby	LGH	LRI

Out- patient specialty	**Current location**	**Future location**
Allergy	LRI	GH – Treatment Centre
Anaesthetics	LGH & LRI	GH – Treatment Centre
Audiology	LRI	LRI & GH/PCA
Bariatric Surgery	LRI	GH – Treatment Centre
Cardiac Rehabilitation	LGH & LRI	Community provision

Chemical Pathology	LGH & LRI	GH – Treatment Centre
Clinical Immunology	LRI	GH – Treatment Centre
Critical Care Medicine	LRI	GH – Treatment Centre
Dermatology	LGH & LRI	GH – Treatment Centre
Diabetology	LRI	LGH
Endocrinology	LGH & LRI	GH – Treatment Centre
ESRF	LGH	GH – Treatment Centre
Gastroenterology	LGH & LRI	GH – Treatment Centre
General Surgery (incl colorectal)	LGH & LRI	GH – Treatment Centre
Geriatric Medicine	LGH & LRI	GH – Treatment Centre
Gynaecology	LGH	LRI

Out- patient specialty	Current location	Future location
Gynaecology Oncology	LGH	LRI
Hepatobiliary & Pancreatic Surgery	LGH	GH – Treatment Centre
Hepatology	LGH	GH – Treatment Centre
Interventional Radiology	LGH	LRI/ GH

Maternity Scans	LGH & LRI	LRI
Neonatal Intensive Care	LGH	LRI
Neonatology	LGH	LRI
Nephrology	LGH	GH – Treatment Centre
Neurology	LGH	GH – Treatment Centre
Neurosurgery	LGH	GH – Treatment Centre
Obstetrics	LGH	LRI
Orthopaedic Surgery	LGH	GH – Treatment Centre
Ophthalmology	LRI	GH – Treatment Centre /PCA
Pain Management	LGH & LRI	GH – Treatment Centre /PCA
Palliative Medicine	LRI	LRI
Plastic Surgery	LRI	GH – Treatment Centre
Pulmonary Rehab	LGH	Community
Renal Access Surgery	LGH	GH – Treatment Centre
Rheumatology	LGH & LRI	GH – Treatment Centre
Sleep	LGH	GH – Treatment Centre PCA
Spinal Surgery	LGH & LRI	GH – Treatment Centre
Sports Medicine	LGH	GH – Treatment Centre

Stroke Medicine	LGH & LRI	GH – Treatment Centre
Thoracic Medicine	LGH	GH – Treatment Centre
Transplant	LGH	GH – Treatment Centre
Out- patient specialty	**Current location**	**Future location**
Urology	LGH	GH – Treatment Centre
Vascular Surgery	LRI	GH

Out- patient specialty	**Current location**	**Future location**
Gynaecology Oncology	LGH	LRI
Hepatobiliary & Pancreatic Surgery	LGH	GH – Treatment Centre
Hepatology	LGH	GH – Treatment Centre
Interventional Radiology	LGH	LRI/ GH
Maternity Scans	LGH & LRI	LRI
Neonatal Intensive Care	LGH	LRI
Neonatology	LGH	LRI
Nephrology	LGH	GH – Treatment Centre
Neurology	LGH	GH – Treatment Centre

Neurosurgery	LGH	GH – Treatment Centre
Obstetrics	LGH	LRI
Orthopaedic Surgery	LGH	GH – Treatment Centre
Ophthalmology	LRI	GH – Treatment Centre /PCA
Pain Management	LGH & LRI	GH – Treatment Centre /PCA
Palliative Medicine	LRI	LRI
Plastic Surgery	LRI	GH – Treatment Centre
Pulmonary Rehab	LGH	Community
Renal Access Surgery	LGH	GH – Treatment Centre
Rheumatology	LGH & LRI	GH – Treatment Centre
Sleep	LGH	GH – Treatment Centre PCA
Spinal Surgery	LGH & LRI	GH – Treatment Centre
Sports Medicine	LGH	GH – Treatment Centre
Stroke Medicine	LGH & LRI	GH – Treatment Centre
Thoracic Medicine	LGH	GH – Treatment Centre
Transplant	LGH	GH – Treatment Centre
Out- patient specialty	**Current location**	**Future location**

Urology	LGH	GH – Treatment Centre
Vascular Surgery	LRI	GH

Appendix D: Tables showing travel analysis information for closing St Mary's Midwife Led Birthing Unit

Negatively impacted postcodes if services shifted from St Mary's to LGH

A change is classed as significant if the impact on travel time is seen to increase travel time by *greater than 5 minutes, and/or increase in cost greater than £1 and/or create a total journey time of over 30 minutes*.

Postcodes negatively impacted when travelling by car

	Increase in Travel time/minutes by car		
Postcodes	Leicester General Hospital/mins	St Marys Hospital/mins	Delta/mins
LE11 1	28	27	1
LE12 5	45	43	2
LE12 7	27	23	4
LE13 0	29	5	24
LE13 1	33	2	31
LE14 2	33	9	24
LE14 3	25	13	12
LE14 4	39	9	30
LE15 6	31	21	10
LE15 7	39	21	18
LE15 8	31	23	8
LE7 4	22	18	4
NG13 0	45	25	20
NG33 5	49	19	30

All except LE11 1, LE12 5, LE12 7 & LE7 4 are materially impacted.

The most significantly negatively impacted postcodes when travelling by car in terms of time, are: LE13 1, LE14 2,LE14 4, NG 33 5.

Postcodes negatively impacted when travelling by public transport

	Additional travel time public transport/mins		
POSTCODE	St Marys Hospital/min	Leicester General Hospital/min	Delta/min
LE130	25	75	50
LE131	10	90	80
LE156	60	105	45
LE7 4	45	60	15

The most significant negative impact of additional travel time by public transport is on the postcode, LE131, (over an additional hour.)

Postcodes materially negatively impacted by an increase in costs (time plus car travel)

	Increase in cost/£		
Postcodes	St Marys Hospital/£	Leicester General Hospital/£	Delta/£
LE12 5	£ 8.23	£ 8.55	£0.32
LE12 7	£ 4.42	£ 4.97	£0.55
LE13 0	£ 0.76	£ 5.47	£4.71
LE13 1	£ 0.32	£ 6.11	£5.79
LE14 2	£ 1.66	£ 6.37	£4.71
LE14 3	£ 2.47	£ 5.00	£2.53
LE14 4	£ 1.74	£ 7.76	£6.02
LE15 6	£ 4.01	£ 6.05	£2.03
LE15 7	£ 4.19	£ 7.59	£3.40
LE15 8	£ 4.59	£ 6.57	£1.98
NG13 0	£ 5.00	£ 9.77	£4.77
NG33 5	£ 3.87	£ 9.54	£5.67

The most significant negative impact in terms of increased cost will be on the postcodes; LE14 4, LE13 1, LE 13 1 and NG33 5

Negatively impacted postcodes if services transferred from St Mary's to the LRI

Postcodes negatively impacted when travelling by car

Postcodes negatively impacted if travelling by car

	Increase in travel time/minutes by car		
Postcodes	**Leicester Royal Infirmary/mins**	**St Marys Hospital/mins**	**Delta/mins**
LE11 1	28	27	1
LE12 7	29	23	6
LE13 0	34	5	29
LE13 1	38	2	36
LE14 2	40	9	31
LE14 3	28	13	15
LE14 4	42	9	33
LE15 6	41	21	20
LE15 7	48	21	27
LE15 8	40	23	17
LE15 9	37	30	7
LE7 3	25	22	3
LE7 4	25	18	7
LE7 9	25	22	3
NG13 0	47	25	22

NG33 5	55	19	36

LE11 1, LE7 3 and LE7 9 are not classed as materially impacted and not considered further.

The most significant negative impact is on postcodes; LE 13 1, LE 14 2, LE 14 4, and NG33 5

Postcodes negatively impacted when travelling by public transport

	Increase in cost/£		
Postcodes	St Marys Hospital/£	Leicester General Hospital/£	Delta/£
LE12 5	£ 8.23	£ 8.55	£0.32
LE12 7	£ 4.42	£ 4.97	£0.55
LE13 0	£ 0.76	£ 5.47	£4.71
LE13 1	£ 0.32	£ 6.11	£5.79
LE14 2	£ 1.66	£ 6.37	£4.71
LE14 3	£ 2.47	£ 5.00	£2.53
LE14 4	£ 1.74	£ 7.76	£6.02
LE15 6	£ 4.01	£ 6.05	£2.03
LE15 7	£ 4.19	£ 7.59	£3.40
LE15 8	£ 4.59	£ 6.57	£1.98
NG13 0	£ 5.00	£ 9.77	£4.77
NG33 5	£ 3.87	£ 9.54	£5.67

The most significant negative impact would be on the postcodes; LE 14 4, LE13 1, NG 33 5

Postcodes materially negatively impacted by an increase in cost (time and travel by car)

	Increase in cost/£		
Postcodes	St Marys Hospital/£	Leicester Royal Infirmary/£	Delta/£
LE12 7	£ 4.42	£ 5.29	£0.87
LE13 0	£ 0.76	£ 6.40	£5.64
LE13 1	£ 0.32	£ 7.04	£6.72
LE14 2	£ 1.66	£ 7.53	£5.87
LE14 3	£ 2.47	£ 5.44	£2.97
LE14 4	£ 1.74	£ 8.20	£6.45
LE15 6	£ 4.01	£ 7.65	£3.63
LE15 7	£ 4.19	£ 8.98	£4.80
LE15 8	£ 4.59	£ 7.97	£3.37
LE15 9	£ 5.93	£ 7.18	£1.25
LE7 4	£ 3.31	£ 4.57	£1.25

NG13 0	£	5.00	£ 10.09	£5.09
NG33 5	£	3.87	£ 10.58	£6.72

The most significant negative impact would be on postcodes: LE13 1, LE14 4, NG33 5

Potential alternative services

It is possible that women who might normally use either St Mary's or the LGH, if the decision is that there is no MLU at the LGH, may choose to access maternity services outside of LLR. An analysis of the impact of this has been done.

Appendix E: Table showing postcodes materially impacted by increased travel times – acute services

These tables are copied from travel analysis report. In addition to these, readers should request the full travel report to view full set of data tables.

Postcode	Potential inpatient activity impacted per annum (stays)	Potential outpatient activity impacted per annum (attendances)	Travel time by car to GH (mins)	Increase versus LGH (mins)	Mitigation (mins)
LE15 6	219	443	40	9	Peterborough & Stamford (33) or Kettering (33)
LE15 7	97	266	46	7	Peterborough & Stamford (33)
LE15 8	62	213	42	11	Kettering (31)
LE15 9	104	291	38	11	Kettering (31)
LE16 7	287	444	33	10	Kettering (19)
LE16 8	163	320	43	10	Kettering (21)
LE16 9	276	501	35	6	Kettering (21)
LE18 1	243	432	18	8	LRI (12)
LE18 2	235	349	21	7	LRI (15)
LE18 3	212	342	27	7	LRI (21)
LE2 1	199	375	12	6	LRI (7)
LE2 2	183	388	17	11	LRI (16)

Postcode	Potential inpatient activity impacted per annum (stays)	Potential outpatient activity impacted per annum (attendances)	Travel time by car to GH (mins)	Increase versus LGH (mins)	Mitigation (mins)
LE2 3	245	467	16	10	LRI (10)
LE2 4	273	467	22	11	LRI (17)
LE2 5	199	381	20	10	LRI (15)
LE5 0	203	302	13	8	LRI (12)
LE5 1	328	471	15	7	LRI (17)
LE5 2	245	409	17	11	LRI (16)
LE5 4	279	367	15	14	LRI (12)
LE5 5	356	417	13	10	LRI (10)
LE5 6	204	396	17	14	LRI (13)
LE7 9	284	500	26	11	LRI (25)
LE8 0	221	444	29	11	Kettering (22)
LE8 8	99	186	28	8	LRI (22)
LE8 9	92	217	25	13	LRI (19)
PE9 3	6	25	49	11	Peterborough & Stamford (23)

Areas considered	Measure	Impact analysis results
Post codes where residents would be materially negatively impacted from a travel and cost perspective	Assessment of comparable travel times by car and public transport. Post codes with increased travel times	LE14 2, LE15 6, LE15 7, LE15 8, LE15 9, LE16 7, LE16 8, LE16 9, LE17 6, LE18 1, LE18 2, LE18 3, LE2 0, LE2 2, LE2 3, LE2 4, LE5 2, LE5 4, LE5 5, LE5 6, LE7 2, LE7 3, LE7 9, LE8 9, PE9 1, PE9 3, PE9 4, NG33 5
Potential residents impacted	Percentage of LLR residents potentially impacted (number in brackets)	37.3% (411269)
Approximate number of inpatient stays that would be impacted	Based on historical stays in 2014/15	2 thousand
Approximate number of outpatient stays that would be impacted	Based on historical data 2014/15	10 thousand
Potential percentage of LLR residents who will be patients negatively impacted	Based on sum or outpatient appointments and inpatient stays	1%

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